STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676463	A. Building B. Wing	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crimson Heights Health & Wellness	19279 McKay Dr. Humble, TX 77338

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47829 Based on interview and record review the facility failed to promote care for resident in a manner and in an environment that maintained or enhanced each resident's respect and dignity for 1 (Resident #1) of 3 residents reviewed for dignity. -The facility failed to provide dignity and respect for Resident #1 by allowing a staff member to provide direct patient care whom Resident #1 had petitioned verbally and via formal grievance not to be involved with his care or have any contact with him. This failure could place residents at risk for suppression of residents' rights, intimidation, retaliation, increased anxiety, and decreased quality of life. Findings include: Record review of Resident #1's face sheet dated 12/14/2023 revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 relevant diagnoses included: quadriplegia (paralysis of all 4 limbs), need for assistance with personal care, adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), neurogenic bowel (loss of normal bowel function), anxiety disorder, conduct disorder (unspecified), muscle weakness, and urinary tract infection. Record review of Resident #1's quarterly MDS assessment conducted 11/2023 revealed Resident #1 had a BIMS score of 15 which indicated Resident #1 was cognitively intact. Record review of the original grievance filed by Resident #1 and provided by a CR written and signed by the Adms D read: Complaint/Grievance: Communicated by: [Resident #1] Communicated to: [Admin D] Concerned about: Care, Violation of Rights (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Describe concern in detail: Due to recent escalating aggressive actions both verbal and physical, my family & I have decided that [LVN B] presents a danger to my immediate and LT health. Signature/Date: [Admin D] 7/20/2023 Documentation of Investigation: Staff Member Assigned Responsibility: [blank] Departments impacted by complaint or grievance: [blank] Findings of investigation: [blank] Result of action taken: [blank] Resolution: [Blank] Record review of the grievance rewritten by the DON and provided 2 hours after the original grievance was requested read: Complaint/ Grievance: Communicated by: [Resident #1] Communicated to: [Admin D] Concerned about: Care Describe concern in detail: Resident unsatisfied with interaction with ADON [LVN B]. He feels as if her tone is aggressive and requested she not be involved in his care. Resident also stated he couldn't sleep at night because of loud TV in neighboring room. Resident asked if we could have him turn off TV. Documentation of Investigation: Staff Member Assigned Responsibility: [DON] Departments impacted by complaint or grievance: Nursing Findings of investigation: The resident's interaction with ADON has been investigated. Plan to resolve includes limiting interactions. Resident educated on residents' rights and that other residents can listen / have on at comfortable volume and if needed he [Resident #1} can also close his door so that the TV does not bother/disturb his rest. Result of action taken: [DON] and ADON [LVN B] will oversee care to limited interaction between [LVN B] and resident [#1} (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resolution: Resident [#1} states he is fine as long as he does not have to deal with ADON [LVN B] Record review of progress note written by LVN B on 7/28/2023 [2:05 AM] read in part: Writer [LVN B] accompanied assigned aide when resident rang bell. Writer assisted assigned CNA in pulling resident up in bed as one person is not able to reposition him safely. Resident then started yelling don't touch me. Writer then did not have any contact with resident as assigned CNA finished up with the bedtime routine. Record review of progress note written by LVN B on 8/11/2023 read: Writer [LVN B] approached resident to give him his morning medications at 4:22am and he stated he did not want writer to give him medication. Writer expressed to him that the other nurse will bring him medications when she is done with her med pass with her residents. Record review of LVN B's personnel file revealed there was no documentation concerning her being asked to stay away from Resident #1 or acknowledging her continued attempts to provide care to Resident #1 after his grievance was filed. Facility was unable to supply documentation of LVN B being instructed to stay away from Resident #1. Interview with the Ombudsman (Omb) on 12/14/2023 at 8:30 AM revealed that he was aware of the complaints of Resident #1 concerning Resident #1 wanting LVN B to stay away from him and not be involved in his care. The Omb said Resident #1 voiced his concerns to him on several occasions, and that he (the Omb) participated in a care plan meeting with the resident and interdisciplinary team a while back. He said he could not recall the date, but Resident #1 expressed concern about the administrative staff (the administrator and DON) not being responsive to his grievance and LVN B still had access to him when he (Resident #1) explicitly requested that she not work with him . Interview with the SW on 12/14/2023 at 12:40 PM revealed that she was aware of Resident #1 having concerns with a staff member but said she could not recall who it was. She said that Resident #1 filed a grievance in June or July of 2023 concerning this staff member, but the resident gave the grievance to Adms D instead of giving it to her. She said that she did not get a copy of this grievance because the administrator is the one over grievances. She said when a grievance is filed, it then goes to the head of the department of which the grievance is related to. In this case, the grievance would have been passed to the DON. The SW said that the DON would have investigated the grievance, completed the grievance form, and filed it with the administrator. Interview with CNA I on 12/14/2023 at 2:17 PM, she said the resident has a right to decline care from a staff member if they want. She said if a resident declines care from a specific person, the charge nurse should be notified, and the staff member swapped out . Interview with LVN Q on 12/14/2023 at 2:34 PM, she said if a resident did not want a certain nurse or aide to work with them, they have the right. She said in this situation, the staff member would be swapped out . [Resident #1 was unavailable for interview on 12/14/2023.] (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 1/11/2024 at 9:11 AM by phone, he said that he had a history of issues with LVN B. Resident #1 said that he filed a grievance in July of 2023 asking that LVN B stay away from him and not be involved with his care. He said that her tone was aggressive, and she wanted to provide care when and how she wanted to instead of following his requests. He felt she did not respect him and was condescending and sarcastic towards him. He said that even after he filed this grievance, LVN B was the ADON and would continue to come into his room to assist staff and rush them with whatever task they were helping him with, despite him telling her to get out and don't touch me. Resident #1 said that he felt LVN B interfered with his care as an ADON by controlling how much time they gave him and what tasks they assisted him with. He said that he believed LVN B instructed nursing staff not to provide him with cough assistance . He said he felt this way because prior to LVN B becoming ADON, he had no issues and was completely satisfied with his care. He said that LVN B has never harmed him physically, but her lack of regard to his request to leave him alone was concerning as well as her ability to interfere with his care using her position. Resident #1 said that back in July when he filed his grievance, he came down to the facility administrative offices to hand the grievance to the administrator. He said he was unable to reach him directly, so he filed his grievance with Admin D. He said that after he turned in his grievance to Admin D, he followed up with DON who he said asked him to give her a chance to resolve the issue with LVN B. He said nothing ever happened and LVN B continued to be involved in his care despite his request. He said the situation has improved since November, but during the period of June through October of 2023, it was a problem. Interview with Adms D on 1/11/2024 at 10:50 AM, She read the copy of the grievance provided by a CR and confirmed that it was her writing and signature, dated 7/20/2023. She said that she completed the grievance and immediately turned it in to the DON and the Administrator. She said she had no further part with this grievance or the investigation of this grievance . Interview with the DON on 1/11/2024 at 11:05 AM, she said she was aware of the past grievance filed by Resident #1, but said she was unable to recall the details of it. Observed on 1/11/204 at 11:06 AM, the DON flipped through the grievance binder for Resident #1's grievance and did not find it there. She was shown a copy of the original, incomplete grievance taken 7/20/2023. Interview with the DON on 1/11/2024 at 11:08 AM, she said she was aware of Resident #1 having verbal complaints about different things. She said she was aware that Resident #1 and the nurse he referred to in the grievance [LVN B] have had not so favorable interactions. She said a care plan meeting was had with Resident #1, the ombudsman, and the IDT team where Resident #1 expressed his negative feelings about LVN B and not wanting her around him. She said she could not recall the date of the meeting. She said Resident #1 declined to have LVN B at the meeting because he did not want her to be around him. She said that at the meeting, she explained to the resident that LVN B did not have to provide direct care to him. She stated as the ADON, she would have to be able to provide emergency assistance such as if he stopped breathing or if an immediate medical decision needed to be made, or if the resident had to be sent out to the hospital. She said Resident #1's response was he would rather . not. She said Resident #1 phrased it differently but said he would not want her care. She said the extent of LVN B's interactions should have been limited to emergency situations and not providing routine care. She said there were 5 nurses working during the day and 3 nurses working at night, so she cannot justify why LVN B was still attempting to provide direct care to Resident #1 after the resident's grievance was filed in July of 2023. She said that she instructed LVN B to stay away from resident #1 unless it was an emergency, however, there was no documentation. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN B on 1/11/2024 at 11:30 AM, she said her job is to make sure all the residents are getting what they need. She said there was an issue in the past where Resident #1 asked that she not be involved in his care. LVN B failed to answer question directly when asked, when were you told to no longer work with Resident #1. She said that as the ADON, she willingly worked the floor so she can be at the bedside, see the residents, and see how things are being done. Again, the ADON did not answer the question of whether she continued to provide direct patient care to Resident #1 after being asked not to. She said at this time, she has no involvement with Resident #1's direct care. She said that if she sees he is not well and needs to be sent out to the hospital or has an emergency, then she will help because it is her job to do so . Interview with the Administrator on 1/11/24 at 4:00 PM, he said the expectation is that if a resident refuses care from a particular staff member, then that staff member would need to find someone else to complete the task. He said there was a call-off on Resident #1's hall and LVN B had to work as a floor nurse. He said he was aware that she attempted to provide care to Resident #1 after the resident had filed his grievance. The administrator did not answer the question directly as to whether and when LVN B was given implicit instruction not to provide direct care to Resident #1. He said that LVN B was not usually a direct care nurse and occasionally would cover a shift if a nurse was needed . Record review of Social Services Policies and Procedures: Complaints/ Grievances Process read in part . The Facility's Leadership will support the patient's/ resident's rights to voice complaints/grievances to the facility or other agencies/entities that hear grievances regarding concerns they have about services and treatment received . 1. The Facility's Leadership will accept grievances/complaints from the patient/resident, family member, or visitor according to Facility Procedures . 2. Facility Leadership acts promptly to understand and resolve complaints and grievances completed in a reasonable expected time frame. 3. After receiving a grievance/complaint, the Facility's Leadership will seek a problem resolution and will keep the patient/resident informed of the progress toward resolution. 4. The Facility's Leadership will protect the patient's resident's right to file a grievance/ complaint without fear of reprisal, discrimination, or interference of the facility staff. 8. A copy of the unfinished grievance is kept with the grievance binder for ensuring all outstanding grievances are returned. Once the completed form is returned =, the unfinished copy may be discarded in accordance with HIPPA practices. 11. Maintain evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision, refer to state requirements .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47829 Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were reviewed and revised by the Interdisciplinary Team after each assessment for 1 (Resident #1) out of 4 residents reviewed for care plan accuracy. -The facility failed to ensure Resident #1's comprehensive care plan identified his need cough assistance related to quadriplegia. This failure could place residents at risk for their medical, physical, and psychosocial needs not being met. Findings include: Record review of Resident #1's face sheet dated 12/14/2023 revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 relevant diagnoses included: quadriplegia (paralysis of all 4 limbs), need for assistance with personal care, adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), neurogenic bowel (loss of normal bowel function), anxiety disorder, conduct disorder (unspecified), muscle weakness, and urinary tract infection. Record review of Resident #36's quarterly MDS assessment conducted 11/2023 revealed Resident #1 had a BIMS score of 15 which indicated Resident #1 was cognitively intact. Record review of Resident #1's comprehensive care plan dated 09/26/2023 revealed the no portion included cough percussion related to quadriplegia. The following areas related to quadriplegia were listed: Problem: [Resident #1] requires assistance with ADL's r/t Quadriplegia. Goal: Will maintain a sense of dignity being clean, dry, odor free and well-groomed over next 90 days. Approach: Encourage independence, praise when attempts are made. Problem: [Resident #1] is at risk for pain r/t musculoskeletal condition. Goal: Will verbalize pain level is being controlled to an acceptable level. Approach: Administer medications as ordered; Assess effects of pain on disturbances in sleep, activity, self-care, appetite, psychosocial, etc.; Monitor and record any verbal or non-verbal signs of pain; Use non-medicated pain relief measures. Problem: [Resident #1] is at risk for falling r/t quadriplegia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Will remain free from injury. Approach: Keep bed in lowest position with brakes locked; Keep call light in reach at all times; Provide an environment free of clutter. Problems: [Resident #1] is limited in physical mobility, bedfast all or most of the time r/t quadriplegia. Goal: Will not exhibit complications of prolonged immobility (e.g., altered self-concept, sensory deprivation, muscle atrophy, contractures, skin breakdown, urinary stasis, infection, urinary incontinence, anorexia, constipation). Approach: Assist [Resident #1] with all ADLs as needed; Conduct a skin assessment . Record review of progress note date 07/01/2023 by MD C revealed: Quick Note: Patient lacks abdominal muscle control and likely incomplete diaphragmatic control. Quad cough is essential to clear secretions. Record review of EMS Run Record dated 10/27/2023 [received 12/15/2023] revealed: Time of PSAP (911 contacted): 3:50 AM Time unit arrived at patient: 4:06 AM Narrative: .dispatched to a breathing problem call and arrived at a nursing/rehab. facility to find a 54 y/o/w/m seated in bed complaining of needing assistance in expelling a mucous plug. The patient presented in no visible respiratory distress but complains of feeling somewhat lightheaded due to his inability to cough up mucous. The patient presents awake, alert and oriented x 4 . The pt was assisted in leaning forward as patient coughed up mucous plug (airway clogging mucous), vital signs unremarkable The patient denies chest pain, abdominal pain, no shortness of breath, no dizziness, no more lightheadedness . Interview on 12/14/2023 at 11:14 AM with MD C, he said Resident #1 had impaired cough secondary to his spinal cord diagnosis (quadriplegia) and did not have the strength in his musculature to cough without assistance. Interview on 12/14/2023 at 11:24 AM with MD B, he said that he ordered the percussion (cough assistance) to release phlegm and help Resident #1 release his mucous. He said that because of Resident #36's bedbound status, he can build up mucous as he was unable to fully release it on his own. He said the percussion is a procedure to help move phlegm. He said that how often it would have been needed would be variable because mucous production varies on an individual basis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/14/2023 at 4:45 PM with the DON, she said Resident #1 was a very intelligent man who was quadriplegic and fully alert. She said that LVN B just wanted to make sure the cough assistance was done in a proper way because sometimes the resident can give instructions that are not always safe. She said on the morning of 10/27/2023 the nurse in the building did not feel comfortable performing the [percussion] procedure. The DON said that percussion to release phlegm was entered into Resident #1's orders on 10/27/2023 after Resident #36 called 911 to receive cough assistance from EMS. She said percussion was not in Resident #1's care plan. She said that the resident has been at the facility since 2021 prior to her being there (2023), and to her knowledge, there was never an order for percussion (cough assistance). She stated it was not in his care plan, so she cannot speak to the history of it. The DON said she was unable to answer why percussion was not in the resident's care plan to-date and whether it should be. In an interview on 12/15/2023 at 7:51 AM with RN D, she said that she was the night supervisor on the night of 10/26/2023 into morning of 10/27/2023. She said that an aid came to her with a question about how to hit Resident #36 on the back. She said that she asked the CNA why she would need to that and she said that the CNA told her because the resident was saying he needed more air or something like that. She said that she did not feel he was in any danger and did not feel comfortable hitting Resident #1's back without an order . Interview with Resident #36 on 1/11/2024 at 9:11 AM by phone, Resident #1 said that he believed LVN B instructed nursing staff not to provide him with cough assistance . He said he felt this way because prior to LVN B becoming ADON, he had no issue receiving cough assistance. He said that cough assistance for him meant to lean him forward and pat (percuss) his back. He said it helped him to release mucous especially at night. Resident #1 said as a quadriplegic, he cannot cough adequately without assistance. He said that he required help coughing because he had mucous which could build up and make it hard to breathe. He said it is an awful feeling to not get help coughing when needed, and at worse, dangerous because the mucous could compromise his airway if he doesn't get help in a timely manner. He said on 10/27/2023, he called 911 because he could not wait on the nurse any longer. He said the EMT assisted him and he coughed up a big mucous plug (air way clogging mucous). In an interview on 1/11/2024 at 12:17 PM with NP A, she said there was a time where Resident #36 was asking staff to percuss his back to aid his cough. She said as a quadriplegic, he did not have the muscle control needed for an effective cough. She said it was okay to percuss resident preferably in bed while one staff member pats his back and the other provided support so he would not fall. NP A said that cough assistance could also be provided in Resident #1's chair if he is wearing a seatbelt and one staff member is present to support him while the other staff member pats his back. Interview on 1/11/2024 at 11:03 PM with LVN O, she said that Resident #1 would ask nursing staff to do things for him that was not in his orders. She said she was not comfortable with a task [cough assistance] that he was requesting. She said that she looked through his chart to see if there was an order or instructions. She said she did not see an order related to cough assistance and she did not feel comfortable doing it. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/12/2024 at 12:55 PM with the DON, she said a complete care plan would allow staff to take care of the resident according to their personalized requirements. She said nurse management (DON, ADON, Charge nurses) were responsible for updating the care plans. She said during morning meetings, nurses communicate what is going on with a resident, and they are also able to pull up physician orders and notes any time to update the care plan. The DON said failure to update and revise the care plan can result in staff not having the instructions needed to provide personalized care for the resident. Interview on 1/12/2024 at 1:15 with the Administrator, he said his expectation is for each resident to have a complete care plan with appropriate updates to reflect their individual needs. He the interdisciplinary team is responsible for reviewing and updating care plans to include problem areas and interventions. Failure to do so can result in the resident receiving inadequate care . Record review of Care Plan Process, Person Centered Care Policy dated 2023 read in part . The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care . The services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan will meet professional standards of quality . Procedures: . 6. The Interdisciplinary Team will review for effectiveness and revise the person-centered care plan after each assessment. This includes both the comprehensive and quarterly assessments . 9. Thru ongoing assessment, the facility will initiate person-centered care plans when the resident' clinical status or change of condition dictates .

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47829 Based on interview and record review, the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 4 of 6 staff reviewed for provision of respiratory care. -The facility failed to assist Resident #1 in expelling mucous from lungs. This failure could place resident at risk for potential respiratory distress, emotional harm, and untimely care. The findings include: Record review of Resident #1's face sheet dated 12/14/2023 revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's relevant diagnoses included: quadriplegia (paralysis of all 4 limbs), need for assistance with personal care, adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), neurogenic bowel (loss of normal bowel function), anxiety disorder, conduct disorder (unspecified), muscle weakness, and urinary tract infection. Record review of Resident #1's quarterly MDS assessment conducted 11/2023 revealed Resident #1 had a BIMS score of 15 which indicated Resident #1 was cognitively intact. Record review of progress note dated 06/19/2023 written by LVN P revealed: Resident was leaned forward while in electric wheelchair as per his request. Resident states this helps him cough his phlegm out. Percussion technique did not take place while in chair at this time due to safety measures. Resident upset that percussion didn't take place. Refusing breathing treatment at this time. States, breathing treatment does nothing for me. No distress noted. NO cough noted. Record review of progress note dated 06/19/2023 by LVN B revealed: . Resident stated 'I do not want any cough medicine. It does nothing for me. I want to be leaned forward and percussed'. Writer [LVN B] expressed to resident that she was not comfortable leaning him forward in his specialized chair to percuss him because the last time it was done resident had to be repositioned > 20 times and while leaning forward he is at risk for fall . Resident appeared in no distress. Record review of progress note date 07/01/2023 by MD C revealed: Quick Note: Patient lacks abdominal muscle control and likely incomplete diaphragmatic control. Quad cough is essential to clear secretions. Record review of progress note dated 09/29/2023 by LVN O revealed: (continued on next page)

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	676463	A. Building B. Wing	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crimson Heights Health & Wellness	19279 McKay Dr. Humble, TX 77338

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pt was insisting to get in propelled position where his face is completely launched forward on bed in highest position and have CNA and myself pat on his back to help with cough. CNA and I expressed we did not feel comfortable doing such task due to resident getting red in the face. Pt kept aggressively saying I need to cough!. Will notify NP for orders to assist pt going forward. Record review of progress note dated 10/27/2023 written by LVN E revealed: Resident requested for CNA back clapping, and CNA reported that the ADON has warned them not to do it, because there was no written order for him for it. Resident was explained that an order was needed for what he was requesting. He insisted and called 911, and they came and performed it for him. Record review of progress note dated 10/27/2023 written by LVN D revealed: Notified by nurse and CNA that resident was requesting for chest physiotherapy/back clapping without an order. Resident assessed with unlabored respiration noted, and no s/s of SOB noted. Resident explained that his healthcare provider has to be contacted to get an order for one. Resident insisted and called 911 and procedure performed at bedside. DON notified. Record review of General Orders for Resident #1. The order description read in part .Order Description: Cough assist daily/ prn Received date: 10/27/2023 Start date: 10/27/2023 . Order Description: Percussion to help release phlegm Received date: 10/27/2023 Start date: 10/27/2023 . Record review of EMS Run Record dated 10/27/2023 [received 12/15/2023] read in part .Time of PSAP (911 contacted): 3:50 AM Time unit arrived at patient: 4:06 AM Narrative: .dispatched to a breathing problem call and arrived at a nursing/rehab. facility to find a 54 y/o/w/m seated in bed complaining of needing assistance in expelling a mucous plug. The patient presented in no visible respiratory distress but complains of feeling somewhat lightheaded due to his inability to cough up mucous. The patient presents awake, alert and oriented x 4 . The pt was assisted in leaning forward as patient coughed up mucous plug, vital signs unremarkable The patient denies chest pain, abdominal pain, no shortness of breath, no dizziness, no more lightheadedness . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/14/2023 at 11:14 AM with MD C, he said Resident #1 has impaired cough secondary to his spinal cord diagnosis (quadriplegia) and did not have the strength in his musculature to cough without assistance. He said cough assistance would allow Resident #1 to have more effective coughs which would help him clear mucous and breath better. He said that he was a consulting physician that made a recommendation and documented in the progress notes. He said as a consulting physician he could make recommendations but the decision of whether to make the recommendation an order would be up to the resident's primary doctor. He said usually nurses would communicate that, but he cannot answer to what did or did not happen between the nurses and the other physician. Interview on 12/14/2023 at 11:24 AM with MD B, he said that he ordered the percussion (cough assistance) to release phlegm and help Resident #1 release his mucous. He said that because of Resident #1's bedbound status, he can build up mucous as he was unable to fully release it on his own. He said the percussion is a procedure to help move phlegm for the resident's comfort and protection of his airways. He said he did not know if there was a previous order for percussion prior to his assuming care of Resident #1. He said there likely was or should have been because it was required for the resident's condition. He said that how often it would have been needed would be variable because mucous production varies on an individual basis . Interview with LVN K on 12/14/2023 at 2:50 PM, she said that Resident #1 is a very bright man. She said he is at the facility because of his quadriplegia, and nothing is wrong with his mind. She said that she listened to what he said or what he asked for because he could express his needs. She said as his nurse, he never asked her to do anything that was unreasonable or that could not be accommodated. She said, but a recurring issue with Resident #1 was him asking for cough assistance. She said that Resident #1 cannot move his body, below neck, and has trouble coughing. She said when he needs to cough, he asks to be leaned forward and his back to pat, that's it [LVN K demonstrated what process looks like]. She said after that, he would cough up whatever (mucous) and would be done. She said until 10/27/2023, there was no order for it. She said the order cleared up the confusion surrounding whether or not to provide the cough assistance. Interview on 12/14/2023 at 4:45pm with the DON, she said Resident #1 was a very intelligent man who is quadriplegic and fully alert. She said in regard to the provision of cough assistance, the ADON [LVN B] wanted to make sure the cough assistance was done in a proper way because sometimes the resident can give instructions that are not always safe. She said on the morning of 10/27/2023 the nurse in the building did not feel comfortable performing the [percussion] procedure. She said instead of the nurse performing the procedure, the resident called 911, an ambulance was sent to the facility, and the EMT provided cough assistance. The DON said the nurse working that night [LVN D] was new to the facility and was not sure if staff was supposed to provide cough assistance because there was no order for it . The DON said that she followed up with they physician to get an order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/15/2023 at 7:51 AM with RN D, she said that she was the night supervisor on the night of 10/26/2023 into morning of 10/27/2023. She said that an aid came to her with a question about how to hit Resident #1 on the back. She said that she asked the CNA why she would need to that and she said that the CNA told her because the resident was saying he needed more air or something like that. RN D said that she went to Resident #1's floor nurse, LVN E, to ask if he had an order for back hitting. LVN E told her that Resident #1 did not have an order. LVN D said that she went to Resident #1's room and did an assessment. She said that she saw he was not short of breath, checked his oxygen sats, all of which was fine. She said that she did not feel he was in any danger and did not feel comfortable hitting Resident #1's back without an order. She said that she stepped out of the room to call the on-call doctor. She said while she was waiting for a call back with an order, Resident #1 called 911 for himself. She said that EMS did come and assist Resident #1 by patting his back and helping him cough. She said she did not get to speak with a doctor, but she notified the DON to follow up. She said when she returned for her next shift, the order had been put in for cough assistance. She said if Resident #1 had a special need for cough assist, then it should have been documented but it wasn't. She the resident did not get what he needed because the order was not in. Interview with Resident #1 on 1/11/2024 at 9:11 AM by phone, he felt LVN B interfered with his care as an ADON by controlling how and what tasks the nurses and aides assisted him with. He said that he believed LVN B instructed nursing staff not to provide him with cough assistance because prior to LVN B becoming ADON, he had no issues. He said the type of cough assistance he required was for someone to lean him forward and pat his back to help him release mucous and cough it up. Interview on 1/11/2024 at 11:30 AM with LVN B, she said cough assistance is called percussing. She said the position that Resident #1 wanted to be put in to do that is not safe. LVN B did not answer the question if she ever instructed staff not to provide cough assistance to Resident #1. She said that Resident #1 wanted to be faced down [suspended from chair]. She said MD Q and NP A told nursing staff not to provide cough assistance because the percussion could trigger tachycardia or some other condition. LVN B said she would have to go through the notes and get documentation about that, and would provide it [no documentation not provided]. She said the doctors became aware that there was a need for the resident to have percussion because the cough medicines and breathing treatments were not working so they went ahead and ordered percussion 10-27-2023. Interview on 1/11/2024 at 12:17 PM with NP A, she said there was a time where Resident #1 was asking staff to percuss his back to aid his cough. She said as a quadriplegic, he did not have the muscle control needed for an effective cough. She said it was okay to percuss resident preferably in bed while one staff member pats his back and the other provided support so he would not fall. NP A said that cough assistance could also be provided in Resident #1's chair if he is wearing a seatbelt and one staff member is present to support him while the other staff member pats his back. She said at no time did she tell staff that percussing the resident's back could trigger any medical condition. She said the purpose of the cough assistance was to help the resident cough effectively and expel mucous. She said this was for his own comfort and safety. Interview on 1/11/2024 at 12:31 PM with the DON, she said there was no order to provide cough assistance for Resident #1 prior to 10-27-2023 because MD Q did not feel comfortable with percussion. She said that she did not receive this info from MD Q, rather the ADON [LVN B] and she just went with it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attempted to call LVN E by phone on 1/11/2024 at 12:45pm, 2:30pm, and 3:30pm, no answer or call back. Interview on 1/11/2024 at 11:03 PM with LVN O, she said that Resident #1 would ask nursing staff to do things for him that was not in his orders. She said that she started working at the facility in August of 2023, when she arrived, Resident #1 already had his own night routine, but she was not comfortable with a task [cough assistance] that he was requesting. She said that Resident #1 asked to be positioned with legs spread apart, almost like a split, and then he would want his chest pushed forward to where his chest and neck were parallel to the floor. She said that she started to do it but when he raised up, his face was red, and she stopped because he was red. She said despite turning red in the face, Resident #1 wanted her to press harder. She said that she positioned him back to normal in bed and went to look through his chart to see if there was an order or instructions. She said she did not see an order related to cough assistance and she did not feel comfortable doing it. She said that she documented that she would notify the NP, but did not because she would not typically contact the NP during night hours unless it is an emergency situation. She said that she handed it off for the morning nurse to notify the NP or doctor. She said usually daytime nurses interact with the NP unless it is critical situation. She said she later found out it's normal how Resident #1 asked her to help him cough, and that it was okay to provide assistance, because an order was entered. LVN O said that no one told her not to assist, but it looked strange, and she felt uncomfortable doing it. She said no training was provided on how to provide cough assistance, but she was told that it was okay to do it how the resident asked. Interview with the DON on 1/12/2023 at 12:55 PM, the DON said that if a consulting physician were to make a recommendation, a nurse should follow up with the resident's physician. She said nurse management including herself (DON, ADON, charge nurse) is responsible for making sure recommendations are followed up on and communicating with the primary doctor to verify if the recommendation is accepted and can be entered as an order. She said the ADON over skilled nursing [where Resident #1 is located] is LVN B. The DON said she said she was not aware that MD C entered the note saying that quad cough was essential. Observed the DON on 1/12/2023 at 12:57 PM verify via web search the definition of a quad cough and read aloud. The DON then went back to MD C's progress note. Interview with the DON on 1/12/2023 at 12:55 PM, she said that the MD C who wrote the progress note about quad cough [dated 07/01/2023] was a consulting physician. The DON said that the quad cough was essential to clear secretions and said that even though MD C said it was essential, he did not say that an order was needed for it. The DON said the resident had not had any complications related to needing quad cough or cough assistance, so an order had not been obtained until October of 2023. She said it was not standard to wait until there was a complication to get an order for a potential problem that has already been identified. When additional level of assistance is needed, nursing is supposed to contact the doctor taking care of the resident to clarify or input the orders. She said if staff expressed being uncomfortable providing resident with the assistance he was asking for, the NP or doctor should have been notified and the issue addressed, then if appropriate, the NP or doctor would have provided an order. She said when the order was obtained in October, the staff were shown how to properly provide percussion (cough assistance) with return demonstration [no documentation]. She said the only assistance Resident #1 required was to be leaned forward and pat on the back. She said failure to adequately communicate/follow up on physician recommendations could result in an order not being carried out in its entirety and staff not knowing what to do. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 1/12/2024 at 1:15 PM with the Administrator (Admin), he said the nurses did not have orders to provide cough assistance and rightfully did not provide it. He said that the staff reached out to the physician for an order, but there was a medical reason why Resident #1 did not have orders for percussion or cough assistance. The Admin said this information did not come from the resident's provider but was told to him by a nursing staff member whom he could not recall. He said that his expectation is for nursing staff to follow orders and to immediately clarify with the primary physician if they are unsure about an order or recommendation . He said failure to do so could cause the resident to receive insufficient care. Record review of Physician and Other Communication/Change in Condition Policy read in part . Policy: To improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding change in conditions . 3.The nurse will document all assessments and changes in the patient's/resident's condition in the medical record. Changes and new approaches will be reflected in the individualized care plan. 4. If the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified. The Medical Director will provide medical orders as necessary to treat the patient's/resident's condition. Record review of Physician Orders Policy read in part . 2. A call is placed to the physician to confirm the orders and request any additional orders as needed. In the event the physician writing the transfer orders is not credentialed by the facility, the designated attending physician is contacted to confirm the transfer orders and request any additional orders . 11. PRN medications: A. Transcribe or electronically enter all PRN Medication/Treatment Orders to properly identified area of MAR. B. PRN orders should specify the condition for which they are being administered e.g., as needed for moderate pain. C. Follow administration procedure as listed .