STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745021	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindale Specialty Care Center	13905 Fm 2710 Lindale, TX 75771

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 - Some	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** 19401 Based on observation, interview and record review the facility failed to ensure residents had the right to be fee from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 4 residents (Resident #1 and Resident #2) reviewed for neglect. 1. The facility failed to ensure the former DON was aware AED pads (AED pad are a vital part of the AED machine that are used to help people experiencing sudden cardiac arrest. The AED pads are place on the person's bare chest and are attached to a cable that connects to the AED to the patient body. The AED then analyzes the hearts rhythm and can deliver an electric shock or defibrillation, to help the heart re-establish normal rhythm.) and Ambu bags (a bag value mask- a handheld tool that is used to deliver positive pressure ventilation to a subject with insufficient or ineffective breaths.) were missing for over 10 days and did not secure supplies. 2. The facility failed to ensure the staff responsible for checking the supplies on the crash cart were following the policy and procedures in place, to either replace the supplies or notify administrative staff the supplies were missing. 3. The facility neglected to ensure necessary supplies were available for tracheostomy residents to have tracheostomy and [NAME] bags at the beside. 4. The facility failed to ensure staff were adequately trained on noninvasive respiratory care. 5. The facility failed to have nurse competency training to ensuring staff were proficient in providing care on noninvasive respiratory equipment. 6. The facility neglected to have a system in place to ensure residents needs were met, with supplies, and training of staff. 7. The facility failed to ensure Resident #1 did not go without oxygen to her brain for about 10 minutes until EMS arrived. 8. The facility failed to ensure Resident #2 had an [NAME] bag or trach at his bed side per physician orders. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of serious harm and possible death. Findings include: 1. Record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included acute respiratory failure and morbid obesity. Record review of Resident # 1's baseline care plan, dated [DATE], reflected she was a full code (CPR to be preformed) there was no additional info documented on the form. Record review of Resident #1's care plan, dated [DATE], reflected a Focused area of Full Code. Some of the interventions were the resident would receive CPR if indicated, and to continue CPR until the resident responded or until EMS arrived to take over the code. A Focused area tracheostomy status and was at risk for increased secretions, congestion, respiratory infections, and infections to tracheostomy. She required a trach Bovina (name brand) flex 7 humidification with air compression at 50 PSI OS at 8 liters per minute via trach collar. Some of the interventions were Ambu bag and an extra inner cannula along with 1 size smaller to be kept at the beside. Monitor oxygen stats and apply oxygen as ordered. Monitor for needed suctioning of increased secretions, congestion assessed for relief. Record review of Resident #1's MDS, dated [DATE], titled other was incomplete. Record review of Resident #1's computerized physician orders reflected BiPap/APAP to be worn at night on at night off in the mornings with setting specified. An order for trach bovina flex 7 extra of that size and one size smaller to be kept in supply box at bedside, dated [DATE]. The resident required Foley catheter care every shift. May change disposable inter canula of trach daily, emergency trach supplies were to be kept at bedside to include oxygen source, suction machine, additional trach and ambu bag. Record review of nursing notes, dated [DATE] at 7:57 p.m., reflected Resident #1 arrived at the facility via EMS. The resident was alert and oriented to self, time, place, situation, and able to make her needs known. She was a full code. Her vital signs were within normal limits, and she voiced no pain. Record review of a RT note, dated [DATE] at 3:41 p.m., reflected Resident #1 was placed on a speaking value and trach was suctioned. Suctioned a small amount of thin white secretions. The patient tolerated the treatment well. Nursing staff on duty instructed on how to place the speaking valve. Time spent 25 minutes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nursing note, dated [DATE] at 3:00 a.m., reflected at 2:15 a.m. CNA called nurse to the room. LVN B went into the room and the resident stated she could not breath and wanted to be switched to her humidified oxygen. LVN B attempted to suction the resident with no secretions removed. The resident went unresponsive with no pulse and no respirations. CPR was started and the crash cart obtained, AE pads applied and 911 called. EMS arrived and CPR continued at 2:32 a.m. pulse obtained but resident continued to be unresponsive, and breaths given via ambu bag continued per EMS instructions. At 2:43 a.m. the resident was transferred to a stretcher, and continued to be unresponsive, pulse continued, continued to administer breaths via ambu bag. At 2:45 a.m. resident transferred to hospital. Note signed by LVN A. Record review of the facility's crash cart check off list [DATE] reflected on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] there were no check offs for those days and the form was not initialed. The rest of the days and the days in between were checked and the form was initialed. Record review of the facility's crash cart check off list for [DATE] reflected there was one day the form was not signed [DATE] all other days were checked as if the supplies were there and signed. Record review of the facility's crash cart check of list for [DATE] reflected on [DATE], [DATE] and [DATE] the slot for ambu bag was circled and checked. All the other dates except [DATE] were checked and initialed. On [DATE] it was not checked or signed. Record review of an EMS report, dated [DATE], reflected they were called at 2:17 a.m. They arrived at the facility at 2:24 a.m. and they were at the patient at 2:25 a.m. The facility staff said Resident #1 had only been at the facility for two days. They reported they were not familiar with her. The staff reported Resident #1 hit her call light and told them she was having breathing problems. The resident had no emergency trach at bedside. All the staff members denied her being their patient and was unable to locate the patient caregiver(LVN A). The staff reported the resident started to turn blue before going into cardiac arrest surrounding 2:15 a.m. The fire department was requested by EMS for lift assistance and possible riders due to the patient, not fitting. The report reflected they arrived at the patient side to find [AGE] year-old female lying in bed with CPR being performed. The patient was pulseless and had her ventilator providing resume breaths. Her face appeared purple and warm and dry skin touch. A rapid assessment was performed and findings were noted on the assessment. The patient was removed from the vent and placed on ambu bag. Staff were informed and squeezed the ambu bag about every six seconds. The patient was applied to monitoring devices via stat pads and found with no heart rate. The staff were struggling when attempted to use the ambu bag on the resident. The staff member used two hands to squeeze. EMS attempted one ventilation switch to replacing the trach. EMS was informed the patient did not have any emergency trach on standby. EMS used the adult [NAME] (a tool used to unclog trach) and forced it past the clotted mucus plug. EMS suctioned the place the resident back on the bag. The [NAME] was covered in thick nasty mucus. The Ambu bag was now easy to squeeze without issue. Staff informed to breathe with ambu bag about every three seconds until she resumed her normal breathes. EMS quickly obtained return of spontaneous circulation (resumed heart rate) and the fire department was called to assist. EMS interventions continued as noted above. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1 hospital records, dated [DATE], reflected per admitting providers documentation. Resident #1 was a [AGE] year-old female with a history of diabetes, high blood pressure, morbid obesity, tracheostomy and feed tube. She presented to the emergency department via nursing facility care on [DATE] after a cardiorespiratory arrest. Per nursing home staff, the patient complained of shortness of breath and having difficulty breathing and became unresponsive with no pulse. They initiated CPR with an approximated downtime of 10 minutes prior to EMS arrival. EMS gave one round of epinephrine (used to improve breathing and stimulate the heart.) Resident #1's heart rate resumed, and she was transported to the emergency room . In the emergency department she was placed on a mechanical ventilation via trach. She was admitted to the ICU after cardiorespiratory arrest. The patient was not waking up despite no sedation medications provided. On [DATE] the patient remained on mechanical ventilation with the assisted control and possible seizure disorder. On [DATE] and MRI of the brain was completed and indicated acute encephalopathy due to Anoxic (complete absence of oxygen in an organ or tissue) and brain injury. During an interview on [DATE] at 5:10 a.m., LVN B said there was an incident on [DATE] on the night shift when Resident #1 coded while she was talking to her, and she had to preform CPR. She said Resident #1 was on a Trilogy respiratory system. The resident was hooked up to the vent at night and during the day they had humidified air connected to the trach. She said they had two other residents on that noninvasive respiratory system Resident #2 and Resident #3. LVN B said she was trained on the system when she first started work at the facility. She said they did not have a full time RT. The RT came to the facility on ce or twice a week. During an interview on [DATE] at 7:00 a.m., LVN E said on Sunday, [DATE], she worked from 6PM to 12 PM shift. She said she had gone to Resident #1's room around 11:00 p.m. to hook up her vent. She said Resident #1 was making phone calls, and she was on the phone with her husband. LVN E said Resident #1 had asked her to wait until she was finished with her phone call. LVN E said she went back maybe 10 to 15 minutes and completed the transfer of Resident #1 to the vent from one air way flow to the other. LVN E said when she put Resident #1 on the vent, she was fine and when she left, she asked the resident if she needed anything. She said she was not at the facility when the resident coded, she had already left for the night. She said she was trained on the trilogy system when she first stated to work at the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 7:38 a.m. the VP of Clinical Operations said the Trilogy system was a noninvasive respiratory support system. She said tracheostomy care was invasive they must go down into the trach to suction. The residents who were on the machinery could breathe without being connected to the machine. She said the vent was on at night only, and they come off during the day. She said they used the AVAPs and BiPap procedure. She said they had a cuff with insulated around the trach itself inflated like a donut around the tube. She said it was the same principle as a catheter ball. The VP said they did not do anything with the setting on the machinery. She said the settings were preset prior to admission by the company staff, and they communicated with the doctors at the hospital, prior to bringing the machinery into the facility. She said staff were only to hook the resident up, unhook them, and provide suctioning as needed. She said they did not change the settings and could not change the settings on the device. She said the nurses were usually trained by the RT when they started work. She said prior to her filling in as the DON, there was no official training on record. She said they did not have any type of nursing check offs. The training that the RT provided her on paper was about trach care and not about the Trilogy machine or devices. On the list of nurses who received the training 4 nurses received the training on [DATE] and three received the training on [DATE]. The VP said she scheduled the RT to do some training on [DATE] and [DATE] with return demonstrations and staff competency check offs so she could have something in their files. During a telephone interview on [DATE] at 10:00 a.m., LVN A said Resident #1 was her resident on the morning of [DATE]. She said she had gone to lunch and was gone about 15 minutes. When she arrived back at the facility LVN B and LVN C were performing the code, EMS was already there when she got back. She said they did 3 or 4 rounds of just compressions, EMS got Resident #1 suctioned. The LVN said when EMS suctioned Resident #1 a lot of blood came out. She said EMS connected the ambu bag to the teach. During a telephone interview on [DATE] at 10:45 a.m., LVN A said Resident #1 did not have a trach at her bedside because she did not see one. She said she did not think EMS asked for one. She said CNA D called LVN B to say Resident #1 was having difficulty breathing. LVN B told her when she arrived in room Resident #1 was talking and when she removed the Trilogy from her and tried to suction her Resident #1 coded. She said then they started CPR. During an interview on [DATE] at 11:45 a.m., LVN G said when Resident #1 came from the hospital they did not send any extra supplies. LVN G said she kept a trach on her cart for emergencies. She said the one she had was for Resident #3. During an observation and interview on [DATE] at 11:40 a.m. of the storage room revealed they had the [NAME] brand name size 8 trach, there were two boxes. The VP said they were all size 8's and they came in this weekend. She said prior to her assuming the DON position she was told supplies were on back order. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:22 p.m., the VP of Clinical Operations said she took the position as acting DON on [DATE] and was informed that day the supplies were not on the crash chart. She said she did do an impromptu in-service about the crash cart and supplies. She said she did not conduct a formal in service because she thought the items were used on [DATE], she did not realize they did not have them to use. The VP said she checked the crash cart to make sure it had everything in place and since she took the position. She had found the ambu bags in a box in the storage room. Thy did not have any AED pads. The VP said she ordered them one day and they were delivered the next day. She said staff members told her the former DON said the items were on back order, however she did not have a problem getting them. She said they now had extra everything. During a telephone interview on [DATE] at 1:00 p.m., CNA D said she and CNA F were walking down the hall and Resident #1 started screaming she could not breath. She said LVN B came into the room and tried to fix her oxygen. CNA D said that did not work, and Resident #1 was turning blue. She said LVN B screamed for LVN C to get the crash cart. She said when they got the chart she knew they could not find something but she did not know what it was. During a telephone interview on [DATE] at 1:05 p.m., CNA F said she and CNA D were walking down the hallway on the morning of [DATE] about 2:00 a.m. They heard Resident #1 say she could not breathe. She said LVN B came in and started checking her tubes. She said LVN B began to try to suction Resident #1, and suctioning did not work. She said the resident started turning blue. She said LVN B began CPR and she and LVN C called for the crash cart. CNA F said there were no AED Pads and no Ambu bag. She said when EMS arrived they had those things. She did not know if EMS was looking for anything or not. During a telephone interview on [DATE] at 1:09 p.m., LVN C said she was down the hall and LVN B screamed her name. She said LVN B was in Resident #1's room and she was a new patient. LVN said she knew nothing about the lady. She said when she arrived in the room Resident #1 was turning blue. She said LVN B was starting CPR and they got the crash cart. She said there were a couple of things missing from the cart, the AED Pads and ambu bag. She told the other nurse to call 911. She said EMS was very quick to respond. She said they did not go the storage room to look for an ambu bag or AED pads. She said they spent their time trying to save the residents life. LVN C said Resident #1 was a large woman, it took both to do compressions and try to suction her. She said when EMS arrived, they put the Ambu bag on Resident #1. She said at first the bag was hard to squish it because there was no airflow. She said they were able not to suction her, however, EMS had a tool to remove the mucus plug. She said when the former DON was at the facility, she was informed they did not have ambu bags, AED pads and supplies. She said since the new DON arrived, they have all the supplies. She said she did not know if Resident #1 had an extra trach at the bedside or not. She was on the other side of the bed. She said EMS did ask if Resident #1 was either one of the nurses patients and she was not. She said Resident #1's nurse was on break. She said she did not know if EMS asked for a trach or not, she barely knew Resident #1's name. During an interview on [DATE] at 2:56 p.m., the ADON said she knew sometimes when she was doing treatments. The former DON said she was having a problem getting supplies and some supplies were on back order. The ADON said the ambu bag was supposed to be on the cart and they had some in a box in the supply room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:10 a.m., LVN I said she started work at the facility on [DATE]. She said on [DATE] she was shadowing LVN A. She said LVN A had left the facility. LVN I said she was in the hallway when LVN B yelled she needed help with CPR. She said she had gone into Resident #1's room and she did not see a trach on her bedside table. LVN I said she did not remember if EMS asked for a trach or not. She said when the crash cart arrived there was no ambu bag or no AED pads. She said the staff were unable to use the AED machine and they did compressions until EMS arrived. She said the resident was probably not breathing for 9 to 10 minutes with no pulse. LVN I said she was in serviced on the trilogy system and trach care but was not comfortable with doing it by herself at the current time. During an interview on [DATE] at 2:04 p.m., the VP said the Trilogy system was not life support. She said residents were able to breath on their own. She said they had red plugs if electricity went out they used the generator. She said she did not know what training the RT had done or what training the manufacture had done. She said they did not have anything written down, and no competency check offs. She said she realized that was a problem and had asked the RT to come and train on [DATE] and [DATE]. She said they needed something in place and they needed to know what staff had what training. The VP said they had nothing when she took the position. She said she did not know why they had the extra trach at the bedside, she did not think the nurses were to replace them. She said she knew with Resident #3 took his trach him when he went to the Pulmonologist. She said they sent the trach with Resident #3 when he went to the hospital in case there were complications. She said the facility nurses never replaced a trach on the inner cannula. During a telephone interview on [DATE] at 2:08 p.m. with the Medical director, he said he was busy and could talk, to talk to the NP. The NP sent a text saying she was busy as well but could answer questions via text. The NP said her expectations of staff was to get vitals every shift, complete trach care each shift and as needed, suction as needed and check on patients every two hours and as needed. The NP said staff should be trained on what to do if the trach got dislodged, how to clean the trach site and do dressing changes. The NP said the noninvasive respiratory system was not life support, the resident received only oxygen during the day. She said if the electricity went they had a generator and the system had a 8 hour battery life. During a telephone interview on [DATE] at 2:15 p.m., the manufacture's Account Executive she said the tracheostomies were invasive and life sustaining she said Resident #2 and Resident #3 had trach and they were invasive life sustain. However, the respiratory system did not classify as life support. She said she talked to her RT to clarify the noninvasive system and was not life support. She said the trilogy system had an 8 hour back up battery. She said the suctioning device was not provided by them. She said she had done some training with the facility nurses, and she could not provide the training information. She said her boss had that information and she was on leave. She did not know how many staff she trained or on what dates. 2. Record review of Resident #2's face sheet reflected he was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Some of his diagnoses included acute respiratory failure and tracheostomy status. Record review of Resident #2's other MDS, dated [DATE], reflected he had severe cognitive impairment. He was totally dependent on staff for ADL assistance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's care plan, dated [DATE], reflected a Focused area of Full Code. Some of the interventions included the resident would receive CPR if indicated, and to continue CPR until the resident responded or until EMS arrived to take over the code. A Focused area tracheostomy status and was risk for respiratory infections, and infections to tracheostomy. He required a trach Shiley (name brand) size 7 humidification with air compression at 55 PSI OS at 8 liters per minute via trach collar. Some of the interventions were monitor for needed suctioning due to increased secretions. Record review of Resident #2's computerized physician orders reflected BiPap/APAP to be worn at night on at night off in the mornings with setting specified. Order for trach information 8 extra of that size and one size smaller to be kept in supply box at bedside, dated [DATE]. Foley catheter care every shift. May change disposable inter canula of trach daily, emergency trach supplies were to be kept at the bedside to include oxygen source, suction machine, additional trach and ambu bag. During an observation of Resident #2's room on [DATE] at 11:45 revealed no trach in the room at his bed side. During an interview on [DATE] at 11:00 a.m., RN J said she started working at the facility on [DATE]. She said when she arrived at the facility today, [DATE], Resident #2's oxygen stats were low. He had orders to switch from the vent to a regular humidifier. She put on 8 liters of oxygen and did not work, his oxygen stats continued to drop. He also had a temperature of 103. She said he had a lot of secretions, and the NP was contacted and said to send him out. The RN said she was trained a little bit on the noninvasive Trilogy system. She said she was not comfortable providing care to Resident #2 and needed more training. She said she went to get a nurse from another hall to assist her with Resident #2's care. During an interview on [DATE] at 11:05 a.m., LVN H said she had worked at the facility for approximately 9 days. She said she had some training on the Trilogy system when she stated, however, she worked with tracheostomy before starting to work at the facility. She said she was provided information on the basic care for trach but was not given any type of skills check off. She said RN J asked her to come and assist her with the Resident #2 care this morning. She showed her how to suction the resident, but he did not handle that well. She said Resident #2's oxygen stats dropped and on further assessment he had a fever. She said the machine had beeped early saying low pressure alarm, and they sent him to the hospital this morning. Record review of the facility's tracheostomy care policy, dated [DATE], reflected the facility would ensure residents who need respiratory care, including tracheostomy care and tracheal suctioning is provided such care, consistent with professional standards of practice, the comprehensive person, centered, care, plan, and residence goes in preferences. The facility will ensure staff responsible for providing tracheostomy care, including suctioning or trained, and competent, according to professional standards of practice. Record review of the facility's policy on tracheostomy care/suctioning, dated [DATE], reflected the facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care, consistent with professional standards, and practice, the comprehensive person, centered, care, plan, and resident goes and practice preferences. The tracheal secretion was performed by licensed nurse to clear the throat and upper respiratory track of secretions that may block the airway. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's noninvasive ventilation policy, last updated [DATE], reflected it is the policy of the facility to provide non-invasive ventilation as per physician, orders, and current standards of practice. AVAP or average volume assured pressure support was a modality of non-invasive ventilation that integrates the characteristics of both volume and pressure controlled, non-invasive ventilation and delivered a fixed digital volume via tracheotomy or a mask that fits over the nose, and or Mouth. A BiPAP or bi-level positive airway pressure was a similar respiratory therapy intervention that delivered an inhale pressure and an excel pressure to provide a patient airway. It required a machine that generated the separate pressures through a two via tracheostomy or a mass that fits over the nose and or mouth. The policy explanation and compliance guidelines. Noninvasive ventilation systems such as CPAP,VPAP, and BiPap and trilogy vary by manufactures common equipment includes the machine tubing mask, headgear straps, dislodge non-disposable filters and humidifier chamber. The facility will obtain an order for the use of a CPAP BiPAP, AVAP or trilogy and settings from the practitioner. Settings will be maintained by the company and the respiratory therapist. The facility will follow manufacture instructions for use of the machine. The facility will assess the integrity around the mask side to ensure there is no impairments to the skin. And document use of the machine, the resident's tolerance, any skin, respiratory or any other changes and response. Follow manufacture instructions for the frequency of cleaning replacing filters and servicing machine. Only the supplier may service the machine. Record review of the facility's, abuse, neglect, and exportation policy, dated [DATE], reflected it is the policy of the facility to provide protections for health, welfare, and rights of each resident by developing, and implementing written policies and procedures that prohibit and prevent abuse, and neglect. Neglect was defined as a fear of the facility, is employees, or service providers to provide goods and services to a resident that is necessary to avoid physical harm, pain, mental anguish, or emotional distress of abuse. The policy indicated, assuring and assessment of resources needed to provide care. Period. And identification is possible of abuse include, but not limited failure to provide care needs This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:00 PM. The Administrator and VP of Clinical Operations were notified and was provided with the IJ template on [DATE] at 4:05 p.m The following Plan of Removal submitted by the facility was accepted on [DATE] at 1:22 p.m.: Problem: F600 Neglect. Goal: Facility will be in compliance with federal health, safety, and/or quality regulations. Its employees or service providers are to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. All nurses will be educated on respiratory therapy for nurses, including but not limited to tracheostomy care, Trilogy care, Tracheostomy suctioning, by the respiratory therapist. Approaches: The VP of Clinical Operations, Clinical Support Specialist, respiratory therapist and ADON will deliver in service education to nurses one on one. If emergency items are on back order from the supplier, the facility is able to obtain said supplies from many of our sister facilities. The Director of Nursing, Administrator, ADON, and Treatment Nurse were educated by the VP of Clinical Operations, to notify the VPCO immediately if emergency supplies are back order and are needed by the facility immediately. This in-service was completed on [DATE].The VPCO will ensure supplies are obtained from a sister facility. (continued on next page)

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	745021	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindale Specialty Care Center	13905 Fm 2710 Lindale, TX 75771

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. The facility medical Director was informed of the IJ on [DATE] by the VP of Clinical Operations. 2. Resident #1 remains in the hospital. 3. Ambu bags, AED, AED Pads, and extra emergency tracheostomy cannulas are available in the facility and on the crash cart, verified by the VP of Clinical Operations on [DATE]. 4. Resident #2 has emergency Ambu bag, emergency tracheostomy cannula in a designated red and black tool box, labeled Ambu bag and extra trach, at the bedside, placed by the VP of Clinical Operations on [DATE]. 5. Each resident in house with a tracheostomy has the emergency box with supplies at the bedside, placed by the VP of Clinical Operations on [DATE]. 6. There are extra emergency Ambu bag toolboxes in the medication room for future residents with tracheostomy's, to be utilized on admission to facility. Nurses were in serviced by the VP of Clinical Operations on [DATE] regarding the new emergency toolboxes. All nurses will be in serviced on this new system before they are able to return to facility for their shift. All new nurses will be trained on this practice prior to starting their shift on the floor. This training will be placed in the clinical orientation packet with HR by the VP of Clinical Operations on [DATE]. 7. All nurses were in-serviced by the VP of Clinical Operations regarding checking the crash cart every night to ensure all items are present on the crash cart according to the emergency crash cart checklist, and any items missing from the crash cart, to notify the DON immediately, so the items can be replaced on the crash cart. The 100-hall nurse is designated to check the crash cart every night, this is included on the in-service given to nursing staff by the VP of Clinical Operations on [DATE]. Also included on the in-service was for the nurses to leave any items that are missing from the crash cart, unchecked on the crash cart log. This in-service was completed on [DATE] by the VP of Clinical Operations. All nurses will be in-serviced on this system prior to returning to their shift. All new nurses will be trained on this practice prior to beginning their shift. This information is added to the clinical orientation with HR on [DATE] by the VP of Clinical Operations. 8. All nurses will be educated on the Crash Cart policy and policy for ensuring emergency equipment for tracheostomy residents including Ambu bag and emergency trach are at the bedside of tracheostomy residents. All nurses on staff at this time besides one that is in the hospital, h [TRUNCATED]

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review the facility failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the residents advanced directives for 1 of 4 residents reviewed for emergency care. (Resident #1) 1. Resident #1 a full code status (a medical code status that indicated to take all steps to save the residents life in the event of cardiac or respiratory arrest, including CPR) turned blue and had no pulse or heart rate, the facility staff requested the crash cart (a cart with emergency medical supplies) when the cart arrived the emergency supplies were missing. 2. The crash cart did not have AED pads for the AED- defibrillator (AED pad are a vital part of the AED machine that are used to help people experiencing sudden cardiac arrest. The AED pads are place on the person's bare chest and are attached to a cable that connects to the AED to the patient body. The AED then analyzes the hearts rhythm and can deliver an electric shock or defibrillation, to help the heart re-establish normal rhythm.) and they did not have an ambu bag- bag mask ventilation (the primary tool for resuscitation in emergency situations such as cardiac arrest). 3. The facility failed to have emergency equipment at the Resident #1's (a tracheostomy resident) bedside as ordered by the physician to include an extra tracheostomy and an ambu bag. The facility nurses did compressions only. 4. Resident #1 was without oxygen to her brain for about 10 minutes prior to EMS arrival and remained unresponsive after she was resuscitated. Resident #1 was placed on hospice due to severe brain damage. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk for not receiving CPR services as needed and being at risk for death. Findings included: Record review of Resident #1's face sheet dated [DATE] indicated this [AGE] year-old female was admitted to the facility on [DATE]. Some of the diagnose were acute respiratory failure, and morbid obesity. Record review of Resident # 1's baseline care plan dated [DATE] indicated she was a full code (CPR to be preformed) other than that the form was basically blank. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan dated [DATE] indicated a Focused area of Full Code. Some of the interventions were the resident would receive CPR if indicated, and to continue CPR until resident responded or until EMS arrived to take over the code. A Focused area tracheostomy status and was risk for increased secretions, congestion, respiratory infections, and infections to tracheostomy. She required a trach Bovina(name brand) flex 7 humidification with air compression at 50 PSI OS at 8 liters per minute via trach collar. Some of the interventions were Ambu bag and an extra inner cannula along with 1 size smaller to be kept at the beside. Monitor oxygen stats and apply oxygen as ordered. Monitor for needed suctioning of increased secretions, congestion assessed for relief. Record review of Resident #1's MDS dated [DATE] titled other was incomplete. Record review of Resident #1's computerized physician orders indicated BiPap/APAP to be worn at night on at night off in the mornings with setting specified. An order for trach bovina flex 7 extra of that size and one size smaller to be kept in supply box at bedside dated [DATE]. The resident required Foley catheter care every shift. May change disposable inter canula of trach daily, emergency trach supplies are to be kept at bedside to include oxygen source, suction machine, additional trach and ambu bag. Record review of nursing notes dated [DATE] at 7:57 p.m. indicated Resident #1 arrived at the facility via EMS. The resident was alert and oriented to self, time, place, situation, and able to make her needs known. She was a full code. Her vital signs were within normal limits, and she voiced no pain. Record review of a RT note dated [DATE] at 3:41 p.m. indicated Resident #1 was placed on a speaking value and trach was suctioned. Suctioned a small amount of thin white secretions. The patient tolerated the treatment well. Nursing staff on duty instructed on how to place the speaking valve. Time spent 25 minutes. Record review of nursing note dated [DATE] at 3:00 a.m. indicated at 2:15 a.m. CNA called nurse to the room. LVN B went into the room and the resident stated she could not breath and wanted to be switched to her humidified oxygen. LVN B attempted to suction the resident with no secretions removed. The resident went unresponsive with no pulse and no respirations. CPR was started and the crash cart obtained, AED pads applied and 911 called. EMS arrived and CPR continued at 2:32 a.m. pulse obtained but resident continued to be unresponsive, and breaths given via ambu bag continued per EMS instructions. At 2:43 a.m. the resident was transferred to stretcher, and continued to be unresponsive, pulse continued, continued to administer breaths via ambu bag. At 2:45 a.m. resident transferred to hospital. note signed by LVN A. Record review the facility crash cart check off list [DATE] indicated on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] there were no check offs for those days and the form was not initialed. The rest of the days and the days in between were checked and the form was initialed. Record review of the facilities crash cart check off list for [DATE] indicated there was one day that the form was not signed [DATE] all other days were checked as if the supplies were there and signed. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review for the facility crash cart check on [DATE] at 11:43 a.m. of list for [DATE] indicated on [DATE], [DATE] and [DATE] the slot for ambu bag was circled and checked. All the other dates except [DATE] we checked and initialed. On [DATE] it was not checked or signed. Record review of an EMS report dated [DATE] indicated they were called at 2:17 a.m. They arrived at the facility at 2:24 a.m. and they were at the patient at 2:25 a.m. The facility staff said Resident #1 had only been at the facility for two days. They reported that they were not familiar with her. The staff reported Resident#1 hit her call light and told them she was having breathing problems. The resident had no emergency trach at bedside. All the staff members denied her being their patient and was unable to locate the patient caregiver.(LVN A) The staff reported the patient stated to turn blue before going into cardiac arrest surrounding 2:15 a. m. The fire department was requested by EMS for lift assistance and possible riders due to the patient, not fitting. The report indicated they arrived at the patient side to find [AGE] year-old female lying in bed with CPR being performed. The patient is pulseless and had her ventilator providing resume breaths. Her face appeared purple and warm and dry skin touch. A rapid assessment was performed and findings were noted on the assessment. The patient was removed from the vent and placed on ambu bag. Staff were informed and squeeze ambu bag about every six seconds. The patient was applied to monitoring devices via stat pads and found with no heart rate. The staff were struggling when attempted to use the ambu bag on the resident. The staff member was using two hands to squeeze. EMS attempted one ventilation switch to replacing the trach. EMS was informed the patient did not have any emergency trach on standby. EMS used the adult [NAME](a tool used to unclog trach) and forced it past the clotted mucus plug. EMS suction the place the patient back on the bag. The [NAME] was covered in thick nasty mucus. Ambu bag is now easy to squeeze without issue. Staff informed to breathe with ambu bag about every three seconds until she resumed her normal breathes. EMS quickly obtained return of spontaneous circulation (resumed heart rate) and the fire department was called to assist. EMS interventions continued as noted above. Record review of Resident #1 hospital records dated [DATE] indicated per admitting providers documentation. Resident #1 was a [AGE] year-old female with a history of diabetes, high blood pressure, morbid obesity, tracheostomy, and feed tube. She presented to the emergency department via nursing facility care on [DATE] after a cardiorespiratory arrest. Per nursing home staff, the patient complained of shortness of breath and having difficulty breathing and became unresponsive with no pulse. They initiated CPR with an approximated downtime of 10 minutes prior to EMS arrival. EMS gave one round of epinephrine (used to improve breathing and stimulate the heart.) Resident #1's heart rate resumed and she was transported to the emergency room . In the emergency department she was placed on mechanical ventilation via trach. She was admitted to the ICU after cardiorespiratory arrest. The patient was not waking up despite no sedation medications provided. On [DATE] the patient remained on mechanical ventilation with the assisted control and possible seizure disorder. On [DATE] and MRI of the brain was completed and indicated acute encephalopathy due to Anoxic(complete absence of oxygen in an organ or tissue) and brain injury. During a telephone interview on [DATE] at 10:00 a.m., LVN A said Resident #1 was her resident on the morning of [DATE]. She said she had went to lunch and was gone about 15 minutes. When she arrived back at the facility LVN B and LVN C were performing CPR on Resident #1. She said EMS was already there when she got back. She said LVN B and LVN C did 3 or 4 rounds of just of compressions, EMS got Resident #1 suctioned. LVN A said when EMS suctioned Resident #1 a lot of blood came out. She said EMS connected the ambu bag to the trach. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 10:45 a.m., LVN A said Resident #1 did not have a trach at her bedside because she did not see one. She said she did not think EMS asked for one. She said CNA D called LVN B to say Resident #1 was having difficulty breathing. LVN B told her when she arrived in the room and Resident #1 was talking and when she removed the Trilogy respiratory system from her and tried to suction her Resident #1 coded. She said then they started CPR . During a telephone interview on [DATE] at 1:00 p.m., CNA D said she and CNA F were walking down the hall and Resident #1 started screaming she could not breathe. She said LVN B came into the room and tried to fix her oxygen. CNA D said that did not work, and Resident #1 was turning blue. She said LVN B screamed for LVN C to get the crash cart. She said when they got the crash chart, she knew they could not find something, but she did not know what it was. During a telephone interview on [DATE] at 1:05 p.m. CNA F said she and CNA D were walking down the hallway on the morning of [DATE] about 2:00 a.m. They heard Resident#1 say she could not breath. She said LVN B came in and started checking Resident #1's tubes. She said LVN B began to try to suction Resident #1, and suctioning did not work. She said Resident started turning blue. She said LVN B began CPR and she and LVN C called for the crash cart. CNA F said there were no AED Pads and no Ambu bag on the crash cart. She said when EMS arrived, they had those things. She did not know if EMS was looking for anything else or not. During a telephone interview on [DATE] at 1:09 p.m. LVN C said she was down the hall and LVN B screamed her she had a code. She said LVN B was in Resident #1's room and she was a new patient. LVN said she knew nothing about the lady. She said when she arrived in the room Resident#1 was turning blue. She said LVN B was starting CPR and they got the crash cart. She said there were no AED Pads and no ambu bag on the crash cart. She told the other nurse to call 911. She said EMS was very quick to respond. She said they did not go the storage room to look for an ambu bag or AED pads. She said they spent their time trying to save the residents life. LVN C said Resident #1 was a large lady it took both to do compressions and try to suction her. She said when EMS arrived, they put the Ambu bag on Resident #1. She said at first the bag was hard to squish it because there was no airflow. She said they were able not to suction her, however, EMS had a tool to remove the mucus plug with. She said when the former DON was at the facility, she was informed they did not have ambu bags, AED pads and supplies. She said since the new DON arrived, they have all the supplies. She said she did not know if Resident #1 had an extra trach at bedside or not. She was on the other side of the bed. She said EMS did ask if Resident # was either one of the nurses' patients and she was not. She said Resident #1's nurse was on break.(LVN A) She said she did not know if EMS asked for a trach or not, she barely knew Resident #1's name. During an interview on [DATE] at 1:22 p.m. the VP of Clinical Operations said she took the position as acting DON [DATE] and was informed that day the supplies were not on the crash chart. She said she did do an impromptu in-service about the crash cart and supplies. She said she did not conduct a formal in service because she thought the items were used on [DATE], she did not realize they did not have them to use. The VP said she checked the crash cart to make sure it had everything in place and had since she took the position. She had found the ambu bags in a box in the storage room. Thy did not have any AED pads. The VP said she ordered them one day and they were delivered the next day. She said staff members told her the former DON said the items were on back order, however she did not have a problem getting them. She said they now have extra everything. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 10:35 a.m., LVN B said she heard beeping and was at the nurse's station. She said she saw the call light go off and headed down the hall. She said she did not hear the resident say anything she mouthed the words. She said Resident #1 said I can't breathe. She said the alarm on the machine was going off as well. The machine read low pressure. She said the resident asked her to please switch her off the ventilator. She said before she could hook the resident up to the humidifier the resident lost pulse. She said the first minute or so the resident had a faint pulse. She said they were unable to get any air into Resident #1's airway because the airway was blocked. EMS unclogged the mucus plug and they were then able to use the ambu bag to get air into Resident #1's lungs. She said a couple of times it appeared Resident #1 took a deep breath. She did not know how long Resident #1 went without air in her system. She said she did not know if the ambu bag would have helped because the airway was completely blocked. LVN B said she could not say if the mucus plug could not have been loosened sooner with the ambu bag. She said there was no ambu bag at the bedside and no ambu bag on the cart. When the cart arrived, there were no AED pads. She said she was told a few days prior the ambu bags and AED pads were on back order by the former DON. She said she checked the cart on the night shift and knew the supplies were not on the cart. She said they had been out of those supplies for a few weeks but were always told they were on back order. She said she had circled a few days when the supplies were not available. (Review of the log showed days circled were [DATE], [DATE] and [DATE].) During an interview on [DATE] at 12:00 a.m . the VP said she did not know what circles on the crash cart check log meant. She said she did not know how long the supplies were missing from the cart. During an interview on [DATE] at 11:10 a.m., LVN I said she started work at the facility on [DATE]. She said on [DATE] she was shadowing LVN A. She said the nurse had left the facility and she was in the hallway when she her heard LVN B yell she needed help with CPR. She said she had went into Resident #1's room and she did not see a trach on her bedside table. She did not remember if EMS asked for a trach or not. She said when the crash cart was arrived there was no ambu bag or AED pads. She said the staff were unable to use the AED machine and they just did compressions u ntil EMS arrived. She said the resident was probably not breathing for 8 to 10 minutes with no pulse. During a telephone interview with Resident #1's family member on [DATE] at 4:00 p.m., the family member said they were told prior to Resident #1 coming to the facility she would only be there for a couple of weeks. They said she was doing well with the trach and the hospital staff said she would likely be able to breathe on her own and have it removed in a few short weeks. The family member said when they arrived at the hospital on [DATE] they were in the room with the physician when he called the facility to ask how long Resident #1 was without oxygen to her brain. She said the physician was told by some nurse about 10 minutes. The family member said the physician was trying to determine why Resident #1 was still unresponsive. The family member said the doctor said it was due to lack of oxygen to her brain for an extended period. She said they were basically told Resident #1 had no hope of survival and was brain dead. The family member said they removed Resident #1 from life support on [DATE] and the moved her to hospice inpatient services on [DATE]. The family member said Resident #1 was still breathing and that was all. The family member said Resident #1 did not respond in anyway, she was just lying in the bed breathing. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's, emergency crash cart and automated extended defibrillators policy, dated [DATE], indicated it was the policy of the facility to ensure that the facility would maintain at least one emergency cart per nursing care floor with additional carts added as deemed necessary in the case of the need for basic life support. In addition, the facility would ensure that at least one AED was available for use in the case of cardiac emergencies. The purpose of this policy was to ensure that all supplies critical to basic life support were readily available on the emergency cart. The facility would store the emergency cart in a location that was readily accessible outside of the office. Equipment supplies for the emergency crash cart or used only when an emergency was provided. Emergency supplies used for an emergency from the crash cart are noted and replace promptly. The emergency cart would be checked every 24 hours and after every use. Missing or expired items were replaced when applicable. The AED was authorized for personal certified in CPR and use of the AED. The AED will be checked every night shift and the battery replace according to manufacturer's recommendations. Follow manufacturer instructions to use of the AED. Clinical staff would be educated on the location use of the emergency cart and the AED. Nursing staff should be familiar with the contents located on and within the emergency card. Record review of the facility's cardiopulmonary resuscitation policy, dated [DATE], indicated it was the policy of the facility to adhere to resident rights to formulate advance directives in accordance with those rights this facility would implement guidelines regarding CPR. The facility will follow American Heart Association guidelines regarding CPR. The website for the American Heart Association indicated reflected performing lifesaving CPR procedures include chest compressions, AED- defibrillator, Ambu- bag mask ventilation, intubation that can produce aerosols. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:00 PM. The Administrator and VP of Clinical Operations were notified. The ----- was provided with the IJ template on [DATE] at 4:05 p.m. The following Plan of Removal submitted by the facility was accepted on [DATE] at 1:22 p.m.: Problem: F678 Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advanced directives. Goal: Facility will be in compliance with federal health, safety, and/or quality regulations. All nurses will be educated on the crash cart policy and where to find emergency medical equipment to perform CPR. All equipment required, including but not limited to, Ambu bag, AED, AED pads, and emergency tracheostomy cannulas, (size according to the resident orders), will be available for use in the facility, and at the bedside of tracheostomy residents, and on the crash cart. Approaches: The VP of Clinical Operations, Clinical Support Specialist, and ADON will deliver in service education to nurses one on one. 1. The facility medical Director was informed of the IJ on [DATE] during an Ad Hoc QAPI meeting, by the VP of Clinical Operations. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Resident #1 remains in the hospital. 3. Ambu bags, AED, AED Pads, and extra emergency tracheostomy cannulas are available in the facility and on the crash cart, verified by the VP of Clinical Operations on [DATE]. 4. Resident #2 has emergency Ambu bag, emergency tracheostomy cannula in a designated red and black tool box, labeled Ambu bag and extra trach, at the bedside, placed by the VP of Clinical Operations on [DATE] . 5. Each resident in house with a tracheostomy has the emergency box with supplies at the bedside, placed by the VP of Clinical Operations on [DATE]. There are currently 2 residents in house with tracheostomy's . 6. There are extra emergency Ambu bag toolboxes in the medication room for future residents with tracheostomy's, to be utilized on admission to facility. Nurses were in serviced by the VP of Clinical Operations on [DATE] regarding the new emergency toolboxes. All nurses will be in serviced on this new system before they are able to return to facility for their shift. 7. All nurses were in-serviced by the VP of Clinical Operations regarding checking the crash cart every night to ensure all items are present on the crash cart according to the emergency crash cart checklist, and any items missing from the crash cart, to notify the DON immediately, so the items can be replaced on the crash cart. Also included on the in-service was for the nurses to leave any items that are missing from the crash cart, unchecked on the crash cart log. This in-service was initiated on [DATE] by the VP of Clinical Operations. All nurses will be in-serviced on this system prior to returning to their shift. 8. All nurses will be educated on the Crash Cart policy and policy for ensuring emergency equipment for tracheostomy residents including Ambu bag and emergency trach care at the bedside of tracheostomy residents. The facility respiratory therapist educated all nurses on the use of the Ambu bag in case of respiratory distress during the on site training on [DATE]. All nurses will be in-serviced on this policy before they return to facility for their next shift by the facility respiratory therapist or RN trained by the facility respiratory therapist before beginning their next shift. 9. All nurses on staff at this time besides one that is in the hospital, have been in-serviced by the VP of Clinical Operations on [DATE]. All nurses will be in-serviced on this policy before they return to facility for their next shift. Monitoring: All new nurses will be educated on the policy for crash cart and emergency tracheostomy supply boxes prior to starting their shift. This information will be included in the orientation packet. Will review for compliance monthly in QAPI X3 months. The DON/designee will monitor daily to ensure all items are present on crash cart and the nurse who checked the crash cart initials are on the crash cart log. Nurses call the DON with any missing items. During observations on [DATE] at 7:15 a.m. with the VP revealed the crash cart was full stocked with AED pads and two ambu bags, and the crash cart check off list was signed. The DNR list was completed on [DATE] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745021	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindale Specialty Care Center	13905 Fm 2710 Lindale, TX 75771

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:15 p.m., the VP of Clinical Operations said she conducted a training with the Administrator, ADON, and the MDS nurse about the supplies being available for emergency use. They were informed if the supplies were low to order them. If there was a problem with receiving the order to notify her. She said they should have the trach at the bedside to give to EMS so they could replace it or take it to the hospital with the residents. She said the staff were in serviced on the crash cart, checking it, making sure supplies were available. They were informed if supplies were not there to notify the DON. During an interview on [DATE] at 1:29 p.m., the Administrator said she was in serviced on the crash cart and missing supplies. She said if anyone told her they were out of supplies and were unable to order them. She would report to the VP immediately. She said she assumed the role of administrator of the facility on [DATE]. She said they had the former DON at that time. She said the staff never reported to her anything about being out of supplies. She said it was the policy of the facility that the DON ordered the supplies. She said she did not check the cart but was educated on the general aspects of the system. She said they did the ad hop QAPI. She said she was still acclimating to the facility, was relatively new to the building and no one made her aware of any issues. Record review of a facility clinical meeting plan indicated ad hoc QAPI meeting dated [DATE] indicated the medical Director was present via phone, emergency supplies at the bedside, emergency supplies being available, and inspection of the crash cart. During observations on [DATE] at 7:15 a.m. with the VP revealed the crash cart was full stocked with AED pads and two ambu bags, and the crash cart check off list was signed. The DNR list was completed on [DATE] . Record review of the crash cart and check off list on [DATE] at 8:00 a.m. with the VP indicated it had been checked for the appropriate days and the supplies were present. Record review of trainings dated [DATE] indicated education was provided on emergency equipment and a test on what equipment could consist of, when to order, who to notify if the equipment need to be ordered, where the equipment was kept and where ventilator patient supplies were kept. Interviews were conducted with facility staff on [DATE]. At 1:57 p.m. ADON RN At2:23 p.m. LVN H worked 6 to 6 p At 2:39 LVN I worked 6a to 6p At 2:48 p.m. RN J worked 6a to 6p At 3:46 p.m. LVN K worked 6p to 6a At 9:14 p.m. LVN L worked 6p to 6a At 9:25 p.m. LVN B worked 6p to 6a (continued on next page)

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	745021	A. Building B. Wing	06/28/2024

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews were conducted with facility staff on [DATE]. At 7:25 a.m. LVN G worked form 6a to 6 p At 7:30 LVN E worked from 6a to 6p. Interviews with nurses indicated they were knowledgeable about the in-services provided regarding CPR and ensuring supplies were on the cart and available. They said if they used emergency supplies, they would replace them, and notify the DON. If they checked the crash cart and supplies were not there, they would not just initial the check list. They would notify the DON, let the Administrator know and if need be, notify the VP of Clinical operations. They were knowledgeable about the black boxes at the bedside of trach residents that contained an extra trach and ambu bag. The nurses said they were not to replace a trach if it became dislodged to call 911 and have the trach for the EMS staff. Record review of a facility clinical meeting plan indicated ad hoc QAIP meeting, dated [DATE], indicated the Medical Director was present via phone, emergency supplies at the bedside, emergency supplies being available, and inspection of the crash cart. Record review of the crash cart and check off list, on [DATE] at 8:00 a.m., with the VP indicated it had been checked for the appropriate days and the supplies were present. Record review of trainings, dated [DATE], indicated education was provided on emergency equipment and a test on what equipment could consist of, when to order, who to notify if the equipment need to be ordered, where the equipment was kept and where ventilator patient supplies were kept. The Administrator and VP of Clinical Operations were informed the IJ was removed on [DATE] at 8:05 a.m.; however, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.