STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675906	A. Building B. Wing	12/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benbrook Nursing & Rehabilitation Center	1000 McKinley St Benbrook, TX 76126

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on observation, interview, and record review, the facility failed to report the results of all investigations to the State Survey Agency within 5 working days of the incident for 2 of 2 (Resident #4 and Resident #5) residents reviewed for abuse, in that: The facility failed to ensure all alleged violations of abuse were thoroughly investigated, the facility failed to complete a provider investigation report, and the facility failed to report the results of the investigation within 5 working days of the incident to the State Survey Agency (Texas Health and Human Services). These failures could place residents at risk of abuse and neglect. Findings included: Record review of Resident #4's face sheet revealed she was a [AGE] year-old female who admitted to the facility on [DATE] with an original admitted [DATE]. Resident #4's diagnoses included encephalopathy, major depressive disorder, single episode severe with psychotic features, unspecified dementia and anxiety disorder. Resident #4 discharged from the facility on 12/03/2022. Record review of Resident #4's quarterly MDS dated [DATE], revealed a BIMS score of 00, which indicated severe cognitive impairment. Record Review revealed there was no incident report for Resident #4. Record review of Resident #4's nurse note dated 11/26/2022 at 11:55 pm written by LVN F revealed resident returned from [Hospital] via [transport company] transport via wheelchair. Assisted to bed via two staff members. Report received from the ER nurse [Hospital RN] and reported that resident had a CT scan done with negative results and Tetanus injection given .Denies c/o pain or distress at this time. No nonverbal signs of pain noted. Dr. [Name] notified. Message left for [family member], will try to reach [family member] again in AM. Administrator notified that resident returned from hospital. Resident noted with red facial bruising to right and left cheek, and bruising around both eyes . Record review of Resident #4's skin observation dated 11/28/2022 revealed there is no skin issues from this fall and no mention of bruising to face. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's nurse note dated 12/03/2022 at 1:30 pm written by LVN B, revealed resident was sent to [Hospital] ER for psych evaluation d/t combative behavior. Record review of Resident #5's face sheet dated 12/09/22, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included encephalopathy, persistent mood [affective] disorder, and dementia with behavioral disturbance. Record review of Resident #5's most recent quarterly MDS dated [DATE], revealed a BIMS score of 7, which indicated severe cognitive impairment. Record review of Resident #5's incident report dated 11/26/22 at 5:32 pm, written by LVN G revealed incident that occurred in Memory Unit in [room number] upon arriving on the unit 2 patients were visualized physically hitting the nurse aide on staff . @this time this nurse called 911, regarding this situation while continuing to calm the area, the patients were arguing and had assaulted one another yelling and screaming This nurse attempted to immediately separate the 2 individuals and instructed the nurse aide to try to 'keep them apart' other patients on the unit appeared to be fine Paramedics arrived with [City] Police, they wanted to 'get a statement from this nurse' I immediately called my administrator and followed her instruction to be seen and taken for evaluation and to treat. At The nearest and closest ER. The police departed telling this nurse that they had and 'could not take either patient to the ER and or the hospital that did not want to go' . Notified administrator with this information There was a report made with the office. Further review of the incident report revealed no injuries observed at the time of incident and no injuries observed post incident. Record review of Resident #5's nurse's note dated 11/26/22 at 11:36 pm, written by LVN F revealed Resident resting on couch in living room .No s/s of pain or distress noted. No behaviors noted. Resident is monitored by nursing staff. Record review of Resident #5's Electronic Health Record indicated the last skin assessment was completed on 11/23/2022. Record review of the intake investigation worksheet priority date 11/29/2022, revealed the facility reported an incident on 11/26/2022 with an allegation of Resident Abuse; the administrator was notified by staff on 11/26/22 at 5:40 pm that Resident #5 was found in Resident #4's room flailing her arms towards her in which resulted in minor scratches and a bruise. Interview on 12/08/2022 at 12:59 pm with the Corporate Compliance RN revealed he spoke with the administrator, and the administrator said she sent the investigation results within five days by email. Surveyor requested a copy of the provider investigation report and confirmation of submission. Interview on 12/08/2022 at 1:34 pm with CNA H revealed she did not see the incident and does not know what happened between Resident #4 and Resident #5. CNA H stated Resident #5 did have a busted lip after the incident but was not there anymore. CNA H stated Resident #5 had a bruise on her left hand on the top, one on the left arm that was clearing up, and none on her body. CNA H stated that she has been hit by Resident #5 before. CNA H stated when a resident is combative to staff or residents, she would try to defuse the situation, talk with the residents and calm them down, and try to remove the one that was more combative. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/08/2022 at approximately 1:40 pm of Resident #5 revealed she was crying and sitting in a chair in the dining room of the secured unit. Resident #5 was not interviewable. Observation of Resident #5 revealed a round bruise on the inside left upper arm about the size of a quarter, that was purple in the middle and yellow on the outside, a bruise on the left hand irregularly shaped about the size of a quarter that was purple, and another round bruise on the right upper arm just above the elbow that was faded and yellow about the same size of the other bruises. Interview on 12/08/2022 at 2:07 pm with the Administrator revealed whenever she does the reports, she sends them via email because she does not have a TULIP account. The Administrator stated she made a mistake on the report for Resident #4 and Resident #5 and sent it in late. The Administrator stated she thought it was due within 10 days. The administrator stated she was trained to email the 5 day. The Administrator stated if an incident was reported, she writes a summary, includes resident information, reports it and does the investigation. The administrator provided a copy of a report and said the first 2 pages are the self-report and the last 3 pages were submitted for the 5 day. Record review of the report (last 3 pages) provided by the Administrator revealed, in part: Description of Allegation: The administrator was notified that Resident #5 was found in Resident #4's room and was flailing her arms towards her in which resulted in minor scratches and a bruise. Actions: - Residents were separated and assessed - Administrator talked with police officer - Informed nurse to conduct assessments of resident and to get x-rays completed - Informed nurse to also notify family and MD .We cannot substantiate any neglect or abuse. The administrator reminded staff to redirect residents as possible and direct them to her if concerns are out of their control. Currently, Resident #5 and Resident #4 do not seem to have any type of distress. Interview on 12/08/2022 at 5:19 pm with Corporate Compliance RN revealed there should have been an incident report for Resident #4 and weekly skin assessments should have been done. The Corporate Compliance RN stated they do skin assessments on paper with 100% skin sweeps monthly. The Corporate Compliance RN stated when there is a reportable, there should be an incident report, training and inservices and for a resident-to-resident altercation, an incident report for both residents, full head to toe assessment on both and it should be documented. The Corporate Compliance RN stated the Administrator and DON are responsible for the investigation. The Corporate Compliance RN stated the risk of not thoroughly investigating was they are not able to determine if substantiated, not substantiated or inconclusive which can give you the ability to put systems in place to make the environment safer. Interview on 12/09/2022 at 8:29 am, the Corporate Compliance RN stated he went over doing investigations with the Administrator, and she had been there for 2 months. The Corporate Compliance RN stated he did a Performance Improvement Plan and the Corporate Administrator will get with the Administrator about doing investigations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of policy titled Abuse Investigation and Reporting, revised December 2016, reflected in part: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported . Role of the investigator: 1. The individual conducting the investigation will, as a minimum: a. review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident . 2. d. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it . Reporting 6. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observations, interviews, and record reviews, the facility failed to provide timely emergency respiratory care consistent with professional standards of practice, including maintaining training for nursing staff regarding expectations for suctioning residents in the on-site dialysis center, for a resident in respiratory distress in the facility's in-house, contracted dialysis center for one (Resident #1) of one resident reviewed for tracheostomy care. 1. Facility staff failed to respond immediately to a request by contract dialysis staff to provide suction for Resident #1 when she had respiratory distress on 10/25/22, at which time Resident #1's distress increased, and she stopped breathing and became unresponsive for an estimated 45 seconds. At this time facility staff began to provide trach suctioning, approximately 12 minutes after dialysis staff initially started attempting to get help from facility staff. 2. A nurse (thought to be LVN J by dialysis staff), refused to provide immediate trach suctioning for Resident #1 on 11/11/22, as requested by contract dialysis staff, when Resident #1 was having gurgling and wet rattling during breathing, and felt she was having increased trouble breathing, and anxiety. This required dialysis staff to attempt to find other nursing facility staff to suction Resident #1's trach, causing a delay in making her comfortable, and a delay in their ability to begin her dialysis treatment timely, and deliver the full treatment. These failures could affect residents with a tracheostomy and in-house dialysis services by placing them at risk of a delay in receiving life-saving treatment which could result in serious injury, harm, and death. Findings included: Review of Resident #1's face sheet dated 12/08/22 reflected she was admitted on [DATE] with diagnoses of acute and chronic respiratory failure, diabetes, malnutrition, pneumonia due to pseudomonas, colostomy, tracheostomy, dialysis for end-stage renal disease, and a feeding tube. Review of Resident #1's MDS assessment, dated 10/20/22, reflected Resident #1 had adequate hearing and clear speech, and was able to understand others and be understood by others. She had A BIMS score of 12, indicating moderate cognitive impairment. During the assessment period she had no behavioral issues or indicators of psychosis. She required limited assistance from one person for dressing and hygiene, and extensive assistance by two people for transferring, moving around in her bed, and toileting. Resident #1 had shortness of breath when sitting, lying, and exerting. Review of Resident #1's dialysis orders, provided by the contract dialysis staff on 12/08/22, reflected she was to receive dialysis for 2 hours and 48 minutes, five times per week. Review of Resident #1's care plans reflected the following: - Care plan dated 10/03/22 The resident needs hemodialysis. The care plan did not address emergencies which occur while in dialysis treatment. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	- Care plan dated 10/26/22 The resident has a tracheostomy r/t respiratory failure. Goals: the resident will have clear and equal breath sounds bilaterally through the review date. The care plan did not address emergency suctioning of the tracheostomy. - Care plan dated 10/26/22 I chose to have FULL CODE. 1. Review of a dialysis progress note for Resident #1 by Dialysis RN Charge, dated 10/25/22, reflected Summary: respiratory distress post-dialysis Note: patient complained something is wrong with her trach after returning blood post HD. I went to look for the SNF nurse to check pt's trach if suction is needed. SNF nurse said, if you can roll the pt in her room, as I am doing something (pertaining to another pt). This nurse went back to dialysis den and pt is having respiratory distress, not responding to verbal stimulus with blank stare approximately 45 seconds, with palpable pulse. Pt is hooked to 02 via trach the whole time. Ambu bag started by nurse (Dialysis LVN). This nurse went to shout for help, while another nurse stays with pt. SNF nurse came with e-cart and suctioning was done and pt became responsive. EMS arrived and evaluated pt. Patient refused to be sent to hospital. (Physician name) notified. Review of a dialysis progress note for Resident #1 by Dialysis LVN, dated 10/25/22, reflected notes throughout Resident #1's treatment on that date, with the last note at 4:00 PM reflecting Tx ended. Pt experience respiratory distress post Tx. SNF staff informed. 12 minutes for Facility respond. Writer administered rescue breaths vi ambu-bag. Staff responded and began suctioning pt. Pt responsive to suctioning. Returned to room /c no further distress. A late entry nursing progress note for Resident #1, entered on 10/27/22 with an effective date of 10/25/22 by MDS Nurse, reflected Notified daughter when daughter arrived at snf of resident having breathing issues during dialysis. Resident was noted to have a readable pulse and O2 but resident appeared to have a change of appearance. Suction was preformed [sic] and O2 was given, 911 was called per Dr. (physician name). Resident was able to resume back to her normal baseline after interventions were done. EMS also stated resident was medically clear. Resident declines wanting to go to hospital. Daughter verbalized understanding. Review of Resident #1's progress note dated 10/26/22, by Corporate Compliance RN (at that time acting as interim Director of Nursing), reflected call RP (RP name) to follow up with resident's episode of difficulty breathing during dialysis. (RP name) did state that she was in the facility and the (MDS nurse) had informed her at the time, she did request to be notified immediately, I did assure her that I would be speaking to staff about her concerns and gave her my personal cell phone so she could contact me for any concerns she may have so they can be handled timely as per her request. I informed her that her mother was doing well this morning and is in no distress. MD was also notified of yesterday's event. Review of Resident #1's progress notes from 10/15/22 and 09/18/22 reflected two prior incidents in which the resident became non-responsive (not in the dialysis center) and facility staff had to call 911, and the resident was taken to the hospital. 2. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Resident #1's progress note dated 09/18/22 reflected PT pushed call light; CNA went in to answer resident was not responding correctly. CNA called nurse, pt was not making eye contact, 20min prior pt was alert and waving, went to check DNR status and grab VS CNA yelled she is not breathing, ran back to room, called for other nurse to call 911, sternal rub applied with agonal breathing, pulse noted strong and regular, inner canula removed scant amount of blood noted to end of canula rinsed, reapplied, fell ow nurse placed ambu bag with 02 per oxygen tank, pt began to open her eyes, suction given to fell ow nurse at this time pt suctioned still continues to have agonal breating [sic], ambu bag reapplied, paramedics arrived on scene. Review of Resident #1's dialysis progress notes by Dialysis LVN, dated 11/11/22, reflected 2:23 PM- Tx started 83 minutes late due to late arrival and request for suction from SNF staff. Writer spoke to (MDS nurse's name) after waiting 40 minutes for suction. (MDS Nurse) stated she believed pt's discomfort was from a history of anxiety and medication refusal. She also stated that there are 3 nurses, capable of suctioning, on the floor, and was unhappy that none of them would come to take care of the pt. (MDS Nurse) proposed that the supplies be held on hand and in the event pt required immediate suction, she would do so personally, and that Social Work would come to speak /c t [sic] the pt to calm her nerves. Tx started w/o further complication art this time. 4:00 PM- Tx ended 72 minutes [NAME] y due to late arrival and pt awaiting suctioning per tx. Tx ended w/o complication. Pt in tx chair to room. Offers no c/o at this time. Review of Resident #1's dialysis progress notes by Dialysis RN, dated 11/11/22, reflected 1:30 PM Upon LATE arrival, DD [sic] nurse (Dialysis LVN) assessing pt nurse noticed wet cough, fluid rattles in trach, and heavy sputum sounds during cough and pt breaths. He then requested for an SNF nurse (LVN J) to suction pt prior to starting HD tx for pt safety reasons. I then left HD unit and found pts nurse (LVN J) and relayed the message for need for trach suctioning. 1:35 PM SNF nurse (LVN J) arrived to HD unit attempting to hand suction supplies to DD nurse (Dialysis LVN). He replied, we are not allowed to do suctioning trach care, that snf nurse must do suctioning. SNF nurse (LVN J) explained that she suctioned pts trach 2.0 hours ago and that these wet breath sounds were normal trach sounds. 1:45 PM SNF nurse (LVN J) left hd unit taking suction supplies with her t [NAME] returned approx 15 min later with the (MDS Nurse's name) who then spoke w/ pt, assessed pts breath sounds through trach. Placed pulse ox on pt, lowered O2 to 3L, read 98% on 3L O2 via trach, and asked pt if she would like to be suctioned, pt replied Yes. HD Nurse (Dialysis LVN name) reminded both (MDS Nurse's name) and SNF nurse (believed to be LVN I) that this pt has previously stopped breathing d/t plugged up trach. 2:00 PM nurse (LVNJ's name) said she was not comfortable to suction the pt. (MDS Nurse's name) said that all snf nurses are capable of performing trach suctioning. (MDS Nurse's name) said she would suction pt (Resident #1's name) and left hd unit. 2:15 PM waiting for (MDS Nurse's name) to return and suction pt before starting dialysis. 2:47 PM SNF SW came to hd unit and spoke with pt regarding anxiety and making chit chat conversation with pt. 4:00 PM (MDS Nurse's name) never returned to suction pt before end of day cutoff time. Review of Resident #1's dialysis progress note by Dialysis RN Charge, dated 11/11/22, reflected Summary: 1:33 PM Pt needing trach suctioned before HD tx. Review of Resident #1's nursing progress note dated 11/11/22 at 11:24 AM by LVN J reflected Trach care provided for patient and hour 30 minutes before dialysis, during this shift and well tolerated. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's dialysis progress note by Dialysis RN, dated 11/11/22, reflected Summary: 3:58 PM Reminded SNF staff to bring Pt on time- Note: Reminded SNF staff to bring Pt on time 5-10 minutes for patient to get complete dialysis treatment, thus have a better chance of (successful treatment) This was endorsed as well to communication sheet. Review of Resident #1's nursing progress note dated 11/11/22 at 6:38 PM by LVN J reflected the resident's vital signs and respiratory status within normal range, and the resident was sent to the hospital per family request due to Resident #1 feeling weak and nauseated. An interview on 12/08/22 at 1:20 PM with Dialysis RN revealed she was filling in while Dialysis RN Charge had a day off. She explained they did in-home dialysis, which was a little different from sending residents out to dialysis. They were a contracted company, housed within the facility. It was different in that they dialyzed residents 5 days a week, instead of three, Monday through Friday, and had shorter treatment times. She said it was beneficial to the residents and facility because they did not have to transport residents, and the shorter, more frequent times allowed residents to be more stable if they came for their full treatment times. She said Resident #1 had treatment time at 1:00 PM, and the 1:00 PM treatment time had a cut-off time of 4:10 PM, which allowed time for dialysis staff to clean the room, re-stock, and prepare the machines for the following days 8:00 AM chair times. She said they had some problems with the facility staff not being responsive to dialysis staff, and not getting residents to the dialysis room (referred to as the dialysis den) on time. During this interview, when Dialysis LVN said that they had trouble getting staff to suction the resident sometimes, and the dialysis staff was not allowed to, Dialysis RN affirmed this. Dialysis RN said that when a resident had high care needs, like a g-tube, or trach, the facility did not seem to have enough staff to get them ready on time for their chair time, and it was detrimental to the residents to have shortened chair times, especially cumulative, over time. An interview on 12/08/22 at 1:26 PM with Dialysis LVN revealed the dialysis staff had trouble with facility staff getting the residents to dialysis on time, and with the facility staff not knowing that they had to attend to resident's trach care during dialysis treatments, because the dialysis staff could not. He said he was not trained for trach care, and their contract said they were not to do it. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	An interview on 12/08/22 at 1:48 AM with Dialysis RN and Dialysis LVN revealed on 11/11/22 Resident #1 came to her treatment late, and her breathing was wet sounding, mucous, loose rumbling, cracking. Dialysis LVN went to find the resident's nurse to suction the resident before they started her treatment. He said the nurse went over the notes with him, and that she had suctioned her already. The nurse wanted him to suction the resident, and he told her they (dialysis staff) could not do it. After that, MDS Nurse came with LVN J to assess the resident and said that the resident had normal trach sounds. Dialysis LVN said they were not normal trach sounds, and he was familiar with the resident. Dialysis RN affirmed that the resident did not normally sound like that during her treatments, and she needed to be suctioned for her own comfort during the treatment. Dialysis LVN said the resident was anxious, and uncomfortable, and she wanted to be suctioned. He said that the nurse he requested to suction her said that she had already done so, and she would hurt the resident if she did it again. He said by that time, she had done it two hours earlier, and she would only hurt the resident if she did it incorrectly, and when a resident needed suctioning, they needed suctioning, even if they were already suctioned previously. He said after assessing Resident #1, MDS Nurse and LVN J, who had refused to suction Resident #1, left the room. He said during this event, when he talked to MDS Nurse, she said to have the (suctioning) supplies ready, and she would come suction in the event of an emergency. He said MDS Nurse seemed annoyed that there were three nurses on the floor who could suction and could not believe any would refuse. He said he believed the resident's nurse that day was an agency nurse. He had never seen her before, and never saw her after that day. Dialysis LVN said that they did put a pulse oximeter (fingertip device for measuring oxygen levels in blood) on the resident during the assessment, and her oxygen was at 98%, but he was concerned because of something that happened before that. He said that there had been a day about a month prior to 11/11/22 when the resident stopped breathing, and it took the facility staff 12 minutes to get there to help. Dialysis RN said they did not come until she started running down the hall yelling for help, because they would not come when initially requested, and when they got there, the cart did not have what it needed, which caused a further delay. An interview on 12/09/22 at 7:55 AM with Dialysis LVN, Dialysis RN, and Dialysis RN Charge revealed Dialysis LVN described an incident on 10/25/22 in which LVN J refused to suction Resident #1. He said the resident had been at the end of her dialysis treatment, and he was rinsing her back (returning the blood to her body), when the resident started to show signs of strained breathing, and gasping, and the resident complained about it being hard to breathe. Dialysis RN Charge said she was just outside of the room at this time, and Dialysis LVN told her the resident was having respiratory distress, and needed to be suctioned, so she went to find someone from the facility to do it. Dialysis RN said the resident's eyes were as big as saucers. Dialysis RN said that the resident passed out before facility staff got to her to suction her, and she was not responsive to vocalization, or sternum rub, and she estimated she was unconscious for a solid 45 seconds. She said facility staff got there within that 45 second period, but it had taken them 12 minutes to get there with the cart, which was missing something. She was not sure it was tubing, because it had been a while, but she thought it was tubing. She said the 45 seconds was an estimate, because she was not looking at her watch, and everything moved very fast when something like that was happening. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few	An interview on 12/09/22 at 8:22 AM with MDS Nurse revealed she felt like they responded fast on 11/11/22, when dialysis staff called out for help with Resident #1. She said when they got to the dialysis room, Resident #1 was lying back in the chair, and they put her upright, to try to clear her (airway), and that helped. She said the dialysis people should have sat her up. She said Resident #1 was very anxious, and the feeling of mucus in her trach was overwhelming for her to swallow and she would panic. She said Resident #1 often refused her antianxiety meds, because she did not want to feel tired when her daughter visited, and her breathing was better when she took them. She said the resident could swallow, but she felt like she could not. She said she and Corporate Compliance RN went into the dialysis room together, and Resident #1's O2 sats were OK, and she had a heartbeat, and she was fine, and normal for herself. She said they called out to everyone to get what they needed, You get the crash cart. You call the doctor. She said someone had to check the resident's code status. She said the resident already had the pulse oximeter and wrist band on, and the dialysis staff was assuming something was wrong, but Resident #1 was not actively passing. She said she and Regional Compliance RN sat the resident up some, brought the crash cart in, and hooked it up. She said everything they needed was on the crash cart. They held Resident #1's hand, and suctioned her, and the resident was not passed out for a long period of time. She said Resident #1 would sometimes become so anxiety-ridden she would pass out a little bit. She said her anxiety was about the trach, and any sort of distress would make her anxious. MDs Nurse said what the resident needed to do was to take deep breaths, but if she could not, she would get anxious and pass out. She said they checked on the resident a lot and reminded her to calm down and take deep breaths. She just needed to be reminded to calm down and breathe. MDS Nurse said Resident #1's eyes were closed, and after they suctioned her, she opened them. She said a person's mental state had an effect on their physical well-being, and Resident #1 passed out from anxiety. MDS Nurse said after they suctioned her, the resident was talking to them, like nothing happened. They had called 911, but the resident refused to go with the ambulance. Transferring was painful for Resident #1, and she was like her normal self-afterwards. She did not require any additional monitoring over what they normally did. MDS Nurse said this was a normal occurrence for Resident #1. She said right after this happened, she thought Corporate Compliance RN talked to the nurses and drilled them about the crash cart and checked the cart. MDS Nurse denied knowledge of dialysis staff attempting to get assistance before she and Corporate Compliance RN went with the crash cart to the dialysis room. She said she thought they had RT come in once a week. She said she felt they had ample staff at the facility, but there might have been a communication barrier between facility staff and dialysis staff. She said the dialysis staff were in their room working and did not always know what was going on with a patient behind the scenes. She said on 11/11/22 she talked to Resident #1's nurse, to see if she could suction the resident, and went to the dialysis room to see the resident. She said they could suction the resident 20 times, and she had a lot of congestion, and would still have congestion. She said if a resident had congestion in their lungs, you could not suction that. She did not feel like the resident was in respiratory distress that day, and she just needed to cough up what was in her chest. She said she felt the dialysis staff were panicked because the resident was a trach patient, even though her vitals were fine. She said she took out Resident #1's canula, and there was no phlegm, and her airway was clear. She said that was expected, and normal for Resident #1. She said they did what they were supposed to do, they assessed the resident, and she did not know what else they needed to do in order to soothe him (Dialysis LVN.) She said if Resident #1 was feeling anxious, and like she needed to be suctioned, they suctioned her. She said Resident #1 had refused her antianxiety medication that day, though she reminded the agency nurses to give it first thing in the morning. The resident refused it often, which was the cause of a lot of her breathing problems, and it was helped by the staff just talking to her and calming her down. She said if she did not feel comfortable with a resident's state, she did not hesitate to send them out, and that she was not here to play with people's lives. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675906	A. Building B. Wing	12/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Actual harm Residents Affected - Few	An interview on 12/09/22 at 8:54 AM with Corporate Compliance RN revealed he denied the incident on 10/25/22 occurred the way it was described by dialysis staff. He denied any knowledge of a staff member refusing to help before he and MDS Nurse heard about it. He said Dialysis RN went down the hall yelling Code blue! Code blue! when he was in the DON's office, in close proximity. He said Dialysis RN panicked, and started yelling, and he and MDS Nurse got up and ran behind her to the dialysis room. He said when they entered the room, Resident #1 was reclined, and she had a pulse, and blood pressure, and she was blinking her eyes and never lost consciousness. He asked the dialysis staff why they did not suction her, and Dialysis RN said they were not allowed to. He said they got the cart, which was fully stocked, into the dialysis room immediately when they went in, and Dialysis LVN was using the ambu-bag on Resident #1's face, even though the resident had a trach, and he explained the ambu bag needed to go through the trach. He said the resident never lost consciousness, and he thought maybe she had a plug. He said they suctioned Resident #1 and she coughed and had a response. He stated she never completely stopped breathing. He said Resident #1 was able to voice, and say she was OK, and they took her back to her room. He said he and MDS Nurse made sure her trach care was done, and that was that. He said Resident #1 never looked any different, and never lost consciousness or had concerning vitals, and refused to go to the hospital. He said after the incident on 10/25/22 they did in-services on trachs, and had the respiratory therapist validate, and do training on trach care and suctioning . He said a couple of days after that, the manager for the contract dialysis company came to meet with him and affirmed that the dialysis staff are not allowed to suction patients. He said the state already reviewed the incident which occurred on 10/25/22. An interview and observation on 12/09/22 at 9:02 AM with Corporate Compliance RN revealed he showed the surveyor each item on the crash cart checklist, as the surveyor read the items off, and explained how some of the items were used. All items on the list were on the cart. Review of the crash cart checklist for October reflected the checklist was checked off and initialed through 10/22/22 but was blank on the dates of 10/23/22 and 10/24/22. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	An interview on 12/09/22 at 9:10 AM with Dialysis RN Charge revealed she was present on 10/25/22. She said she was not sure how much time elapsed between when she went to get help for Resident #1 and when nursing facility staff came with the crash cart, but she felt it was way too long. She said as a hospital nurse, when someone needed to be suctioned, she would expect a response to be urgent, within a minute, but she estimated at least five to six minutes for the facility to respond, though she was not sure, because she was not looking at her watch, she was trying to get help. She said that airway problems were number one priority, and a nurse should drop what they were doing, to attend to it. She said she was outside the dialysis room at first, and when she stepped in, the resident's blood was not in the machine (the dialysis had not been started), and Dialysis LVN said there was something wrong with Resident #1's trach. She said she told him to take Resident #1's oxygen saturation reading, and she would go get a facility nurse to suction. She said the resident was responsive when she left the room, and OK. She said she was rushing and was looking through all the rooms when she found a nurse (identity unknown) in a resident room, the nurse told Dialysis RN Charge to move the resident out of the dialysis room and she would come take care of it. Dialysis RN Charge said she told the nurse the resident was in the dialysis chair, and she needed to go to the dialysis room. Dialysis RN Charge said she stood there by the door for an unknown number of minutes and could see the nurse was not going to go with her, so she went to check on Resident #1. When she got back the resident was worse and Dialysis RN went out into the hall to yell for help and she (Dialysis RN Charge) stood in the door of the dialysis room and yelled. She said MDS Nurse and Corporate Compliance RN came and brought the crash cart, but it was missing a part, so she went to find the thing they were missing. She said she thought it was a connector for the suction, but she was not sure, because of how long ago it was. She said Dialysis LVN had started using the ambu bag but that would not help if the trach was blocked. She said she returned with the part, and they had found what they needed on the cart. She said the resident had become unresponsive when she returned. Dialysis RN Charge said someone had already called 911, and when they arrived Resident #1 was fully awake. She said the resident was evaluated and refused to go to the hospital. She said after the incident she called her manager, because they were not allowed to suction a resident, and needed a faster response form the facility. She said they had a meeting attended by herself, her manager, and Corporate Compliance RN, and Corporate Compliance RN said it would be better to not admit trach patients, because the staff might not be able to respond fast enough. She said there were no trach patients on dialysis in the facility now, and she felt that was safer, because the dialysis staff were not allowed to suction, and they did not receive training from their company. She said she knew how to do it but had been instructed repeatedly by her manager that they do not, and it had to be done by facility staff. She felt this happened because there was not enough staff in the facility, and always different staff, so there was no continuity for patients. She said she wished she had taken more detailed notes, and some of the details were not clear in her memory, but it was clear that suctioning did not happen fast enough, and the nurse she informed should have dropped what she was doing and gone to help Resident #1 immediately. On 11/11/22 when Resident #1 needed to be suctioned, and Dialysis LVN was trying to get someone from the nursing facility to suction her. She said the resident was 30 minutes late for her appointment, and they did not want to start her treatment until she was comfortable. She said staff had been instructed to suction residents 30 minutes to an hour before their dialysis treatment time. When Dialysis LVN told the nurse (LVN J), who was not familiar to her and she had not seen since that day, that the resident needed suctioning, the nurse said she already did it two hours prior, and the wet sounds were normal for a trach patient. The LVN J tried to get Dialysis LVN to suction the resident, and he told her they were not allowed to. Dialysis RN Charge said the resident did not usually have the gurgling and wet breathing sounds she had that day or complain about it during dialysis. She said the nursing facility had the pulse oximeter and the dialysis center did not have one, so they were unable to check her O2 sat. Dialysis RN Charge said when they tried to get the resident suctioned on 11/11/22, the facility nurse stood there and talked and argued and refused for 10 minutes then left with the suction supplies she had brought to give to Dialysis LVN so he could suction the resident. Dialysis RN Charge said 15 minutes later, the facility nurse returned with MDS Nurse, who spoke with the resident, took her O2 sat, and assessed the resident's breath sounds. She said MDS Nurse asked the resident if she would like to be suctioned, and Resident #1 said yes. She said during this time Dialysis LVN reminded MDS Nurse and the facility nurse that the resident had previously stopped breathing the month

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F 0695 Level of Harm - Actual harm Residents Affected - Few	An interview on 12/09/22 at 10:59 AM with the Administrator revealed the staff would normally do an incident report on something like the incident in the dialysis center on 10/25/22. She said they did do notes on it. She did not indicate why an incident report was not done. An interview on 12/09/22 at 11:23 AM with RT revealed he had worked full time at the facility for about seven years, but that was years ago. He said occasionally he would go in when they called him, but it was infrequently. He said he could not remember exactly when, but months ago he had gone there to do an in-service for them on suction of trach, emergency airway maintenance, and such. He said August sounded about right (when surveyor asked about in-service documentation with his name on it, from August 2022), and he had not done an in-service since then. He said he was not directly involved with Resident #1 but knew who she was and had checked on her when he was there. He said he did not make notes, and it was too long to remember details. He said the nurses should have made notes on it. He did not in-service in October and was not involved with any incident with the resident then. He did not know about it. An interview on 12/09/22 at 11:32 AM with Corporate Compliance RN revealed they currently had no patients with a trach in the facility and had not since Resident #1 was discharged . An interview on 12/09/22 at 12:19 PM with the Administrator revealed they did QAPI the incident but the only staff member they still had from the administrative team at the time of the incident on 10/25/22was MDS Nurse. She said LVN I was no longer an employee. She said they did discuss the incident, and maybe she should have done a PIP, but she has no people and had a brand-new DON and ADON. She said when the incident in October happened, she could hear the nurses yelling, and MDS Nurse and Corporate Compliance RN ran, as fast as they could, to help. She was not aware that a nurse had already been asked to help, and only knew about the dialysis nurses yelling in the hall, and Corporate Compliance RN and MDS Nurse running out of the office to help them. She said that they w [TRUNCATED]