STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525359	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Ridge Health Services	2730 W Ramsey Ave Milwaukee, WI 53221

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interview, the facility did not ensure 1 Resident (R2) of 3 sampled Residents were treated with dignity and respect. *The facility sent R2 to a chemotherapy appointment covered in emesis. Findings Include: R2 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy, Malignant Neoplasm of Colon, Chronic Obstructive Pulmonary Disease, Legal Blindness, and Essential Hypertension. R2 has an activated Health Care Power of Attorney (HCPOA). R2's Quarterly Minimum Data Set (MDS) completed 9/12/24 documents R2's Brief Interview for Mental Status (BIMS) score to be 4, indicating R2 demonstrates severely impaired skills for daily decision making. R2 is documented as having no mood or behavior issues. R2's MDS also documents R2 is independent with eating, has range of motion impairment on both sides of lower extremity, requires substantial/maximum assistance for showers and upper dressing. Partial/moderate assistance for lower dressing, mobility and transfers. R2's MDS documents R2 to always be incontinent of bladder and frequently incontinent of bowel. On 10/9/24, at 10:29 AM, Surveyor interviewed Receptionist at the Cancer Center (REC)-C via telephone. REC-C reported the van driver who transported R2 was appalled at the condition of R2. In particular, the day R2 was covered with emesis all down the front of R2. The nurse at the Cancer Clinic (RN)-D reported that RN-D noticed on several occasions R2 has been wet from urine. R2 has had R2's mask filled with food. RN-D confirmed R2 arrived covered in emesis to the clinic. RN-D stated R2's tubing was filled with emesis and that it had hardened and smelled so bad. On 10/9/24, at 11:25 AM, Medical Records (MR)-E confirmed that MR-E is responsible for scheduling of appointments and arranging transportation for the residents. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24, at 11:42 AM, Surveyor interviewed via telephone Office Manager (OM)-F of the transportation company. OM-F informed Surveyor OM-F recalls the incident with R2. OM-F stated the van driver informed OM-F that when the van driver picked up R2 from the facility, R2 was covered in dried emesis. The van driver informed the person at the desk (of the Facility), who acted like they didn't care. OM-F stated the person at the desk would not take R2 to get changed before leaving the facility to go to the Cancer Center for chemotherapy. OM-F stated OM-F called the facility and reported the details to MR-E. OM-F informed Surveyor the incident occurred on 9/19/24. On 10/9/24, at 12:04 PM, Surveyor spoke with the Van Driver (VD)-G. VD-G informed Surveyor R2 was completely full of emesis the day VD-G picked up R2 to transport to the Cancer Clinic. VD-G stated that was the first time VD-G transported R2. VD-G stated R2 was brought up front late, a little over 20 minutes VD-G waited for R2. VD-G talked with the nurse at the Cancer Clinic about it and the nurse stated R2 has been soaked in urine at times. On 10/9/24, at 2:01 PM, MR-E denies receiving any phone calls from OM-F in regards to R2. On 10/10/24, at 11:06 AM, Director of Social Services (DSS)-K stated R2 is gone for R2's chemotherapy appointment for about 5 hours and about 30 minutes the second day to get R2's port out. On 10/10/24, at 11:25 AM, Surveyor shared the concern with Director of Nursing (DON)-B that R2 arrived to the Cancer Center covered in emesis, compromising R2's dignity. No further information was provided by the facility at this time.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observation and interview, the facility did not ensure a clean, comfortable, and homelike environment which had the potential to affect 2 (R1 and R2) of 3 wheelchairs observed during the survey process. *R1's wheelchair was observed to be dirty during the survey. *R2's wheelchair was observed to be dirty, and the arm rests in need of repair during the survey. Findings Include: R2 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy, Malignant Neoplasm of Colon, Chronic Obstructive Pulmonary Disease, Legal Blindness, and Essential Hypertension. R2 has an activated Health Care Power of Attorney (HCPOA). R2's Quarterly Minimum Data Set (MDS) completed 9/12/24 documents R2's Brief Interview for Mental Status (BIMS) score to be 4, indicating R2 demonstrates severely impaired skills for daily decision making. R2 is documented as having no mood or behavior issues. R2's MDS also documents R2 is independent with eating, has range of motion impairment on both sides of lower extremity, requires substantial/maximum assistance for showers and upper dressing. Partial/moderate assistance for lower dressing, mobility and transfers. R2's MDS documents R2 to always be incontinent of bladder and frequently incontinent of bowel. On 10/9/24, at 11:04 AM, Surveyor observed R2's wheelchair. Both arm rests are missing the leather covering the foam. The right arm rest foam is mostly exposed with very little leather covering the arm rest. Surveyor observed dried food on the center of the wheelchair on both sides under the seat of the wheelchair. The wheels are dirty and dusty. R2's wheelchair brakes are covered with dried food crumbs. On 10/9/24, at 11:28 AM, Surveyor interviewed Maintenance Director (MD)-R. MD-R stated 3rd shift staff completes the task of cleaning the wheelchairs. MD-R stated they rely on staff communicating to MD-R if a wheelchair needs to be repaired. On 10/9/24, at 3:03 PM, Director of Nursing (DON)-B stated that wheelchairs are cleaned on the night shift on shower days and as needed. On 10/10/24, at 7:42 AM, Surveyor notes R2 was to have a shower on 10/9/24, which means that R2's wheelchair should have been cleaned on night shift on 10/9/24. On 10/10/24, at 8:15 AM, Surveyor observed R2's wheelchair continued to be dirty as observed on 10/9/24, evident of R2's wheelchair not being cleaned on R2's shower day. R2's arm rests remain in poor condition and in need or repair with exposed foam. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24, at 10:33 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-H. CNA-H stated wheelchairs are cleaned on 3rd shift and should be in the CNA assignment book as a task. On 10/10/24, at 10:34 AM, CNA-J informed Surveyor that 3rd shift washes the wheelchairs. CNA-J stated if CNA-J observed anything needing to be fixed on a wheelchair, CNA-J would let the maintenance department know. On 10/10/24, at 11:25 AM, Director of Nursing (DON)-B and Surveyor both observed R2's wheelchair together. DON-B agreed R2's wheelchair was filthy and both arm rests needed to be replaced with new ones. DON-B stated she understands Surveyor's concern with the dirty wheelchair. DON-B confirmed 3rd shift should be cleaning wheelchairs and is part of the CNA assignment. DON-B stated that wheelchairs can be cleaned as needed. No further information was provided by the facility at this time. 20483 2.) On 10/9/24, at 8:52 a.m., Surveyor observed under R1's roho wheelchair cushion there are multiple small food crumbs and debris throughout the wheelchair seat. On 10/10/24, at 8:03 a.m., Surveyor observed under R1's roho cushion there are multiple small food crumbs and debris throughout the wheelchair seat. On the front edge of the wheelchair seat there is dried food. On 10/10/24, at 11:25 AM, a Surveyor interviewed Director of Nursing (DON)-B in regards to the procedure for washing wheelchairs. DON-B explained that wheelchairs are expected to be cleaned on 3rd shift as part of the CNA assignment and as needed on the Residents' shower day when staff see the wheelchair needs to be cleaned. DON-B was informed of the observation of R1's dirty wheelchair.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure residents received treatment and care consistent with N6 Wisconsin Nurse Practice Act for 2 (R3 & R1) of 4 residents reviewed. R3 was admitted to the facility on [DATE]. During the night of [DATE], R3 experienced a change of condition including having shortness of breath, increased pulse and respirations, and oxygen (O2) saturations of 65% (as obtained by Licensed Practical Nurse (LPN)-N. LPN-N sought out Registered Nurse (RN)-L for a second opinion. LPN-N and RN-L had a miscommunication as RN-L believed R3's O2 sats were 85%. RN-L listened to R3's lung sounds but did not complete a comprehensive assessment of R3's change of condition. LPN-N obtained an order to transfer R3 to the hospital and called a private ambulance service. Upon EMS arrival, they found R3 to be in severe respiratory distress and unresponsive. R3 passed away in the ambulance while still at the facility. The facility's failure to have effective communication of R1's medical status between RN-L and LPN-N, the failure to complete a comprehensive assessment of R3's status by RN-L, the failure to recognize the acute change in condition to include hypoxia, and the delay in providing emergency medical care to R3 by not calling 911 when R3's oxygen saturation was 65% created a finding of Immediate Jeopardy (IJ) which began on [DATE]. NHA (Nursing Home Administrator)- A, DON (Director of Nursing)-B, & [NAME] President of Success-Q were notified of the immediate jeopardy on [DATE] at 2:03 p.m. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope and severity of D (potential for harm/isolated) related to the example involving R1 and as the facility continues to implement its action plan. *R1 was observed without the right lower extremity tubi grip on [DATE] & [DATE]. Findings include: The facility's policy titled, Change in Condition of the Resident and reviewed/revised [DATE] under Policy documents: A facility should immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). According to the State of Wisconsin Nurse Practice Act: N 6.03 - Standards of practice for registered nurses. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(1) General nursing procedures. An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.'s or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. According to https://www.yalemedicine.org People should contact a health care provider if their oxygen saturation readings drop below 92%, as it may be a sign of hypoxia, a condition in which not enough oxygen reaches the body's tissues. If blood oxygen saturation levels fall to 88% or lower, seek immediate medical attention. R3 is an [AGE] year-old male admitted to the facility on [DATE]. R3 was hospitalized from [DATE] to [DATE] following a fall in the bathroom. R3 presented to the ED (emergency department) in A Fib (Atrial Fibrillation) with rapid venticular response, concern for ST (sinus tachycardia), and troponin elevation. R3 received heparin during hospitalization but was transitioned to low dose Eliquis. R3's diagnoses include non-sinus tachycardia myocardial infarction, syncope and collapse, chronic kidney disease with heart failure, diabetes mellitus, depressive disorder, atrial fibrillation, and presence of left artificial hip joint. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3 was his own person and did not have an activated power of attorney for health care. The nurses note dated [DATE], at 17:05 (5:05 p.m.), documents: Resident is on follow up for: New Admission. The current status is Resident arrived facility at 1500 (3:00 p.m.) from [hospital initials]. Resident was in hospital after a fall at home. Resident has complaints of mild pain in both hips and lower back. Resident uses urinal in bed and is a check and change for BM (bowel movement) due to weakness until evaluated by therapy. Active bowel sounds in all four quads (quadrants), Lungs clear. Hospital states resident would be a candidate for sit to stand but it was never attempted in hospital. Resident is A&Ox3 (alert and orientated times three) sometimes a bit confused but easily redirected. Resident has a friend [first name] that is very involved and visits often. This nurses note was written by LPN (Licensed Practical Nurse)-T. The nurses note dated [DATE], at 00:38 (12:38 a.m.), documents: Resident is on follow up for: New Admission. The current status is Resident in bed resting with eyes closed at this time. Follow up, new admit. Resident adjusting well to facility. No c/o (complaint of) pain or discomfort. No sob (shortness of breath) or respiratory distress noted. All cares provided by staff PPOC (per plan of care). Will monitor. This nurses note was written by LPN-U. The nurses note dated [DATE], at 08:29 (8:29 a.m.), documents: Resident is a new admit who went into hospital after a fall at home. Resident has complaints of mild pain in both hips and lower back. Resident uses urinal in bed and is a check and change for BM due to weakness until evaluated by therapy. Active bowel sounds in all four quads, Lung clear. Hospital states resident would be a candidate for sit to stand but it was never attempted in hospital. Resident is A&Ox3 some confused at times but easily redirected. We will cont. (continue) ppoc. This nurses note was written by LPN-M. The nurses note dated [DATE], at 19:25 (7:25 p.m.), documents: Resident is on follow up for: New Admission. The current status is Follow up, new admit after a fall at home. Resident adjusting well to facility. No c/o pain or discomfort. No sob (shortness of breath) or respiratory distress noted. All cares provided by staff PPOC. Resident here post fall at home, resident here for weakness and strengthening. This nurses note was written by LPN-T. Review of R3's oxygen saturation under the weight/vitals tab reveals the following: [DATE], at 1543 (3:43 p.m.) 95% on room air. [DATE], at 0445 (4:45 a.m.) 93% on room air. [DATE], at 1132 (11:32 a.m.) 95% on room air. [DATE], at 1632 (4:32 p.m.) 96% on room air. [DATE], at 0131 (1:31 a.m.) 65% on room air. Review of R3's pulse under the weight/vitals tab reveals the following: [DATE] at 1543 (3:43 p.m.) 74 bpm (beats per minute). [DATE] at 0445 (4:45 a.m.) 65 bpm. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 6:30 a.m., Surveyor interviewed LPN-N, who was assigned to care for R3 and was the charge nurse for her shift on [DATE]. Surveyor asked LPN-N to walk Surveyor through what happened on [DATE] with R3. LPN-N informed Surveyor R3 was basically a new patient, he was doing fine, on report for new admission. LPN-N informed Surveyor she doesn't know the exact time, probably around 1:50 a.m. to 2:00 a. m., R3 had his call light on. LPN-N informed Surveyor she answered the light because the CNA was on break. LPN-N informed Surveyor she went into R3's room and he was having a hard time breathing so I asked him if this just started. LPN-N informed Surveyor she went to grab all her vital sign things, blood pressure cuff, pulse ox, thermometer. LPN-N informed Surveyor R3's SPO2 was 65%, R3 said this just started and she went to go look for oxygen and to get the other nurse. LPN-N then stated, I think I called her because I wanted to get the O2 (oxygen). LPN-N informed Surveyor she went back to R3 and thinks started the oxygen at 2 liters. LPN-N informed Surveyor R3's pulse ox was not going up, so she put a mask on him & increased the oxygen to 3 liters then the RN [RN-L's first name] was in assessing R3 as I wanted her to be a 2nd person. Surveyor asked if R3's oxygen saturations increased. LPN-N informed Surveyor it stayed at 65%. We listened to R3's lungs, could hear trach congestion and wheezing. LPN-N informed Surveyor they ended up calling [name of medical group] and the NP said okay to send to [hospital name]. LPN-N informed Surveyor she called the ambulance, emergency contact, and called in report to the RN at the hospital. LPN-N informed Surveyor a little while later, [name] ambulance came in and told her R3 had expired, and the protocol is for the cops to come so they will be talking with us. Surveyor asked who called the ambulance. LPN-N replied, I believe I did. Surveyor asked who she called. LPN-N stated [Name] of ambulance company. Surveyor asked LPN-N why she didn't call 911. LPN-N replied, the nurse practitioner didn't specify to call 911. LPN-N informed Surveyor she was conferring with the RN and asked if they should call 911 before. Surveyor asked LPN-N what assessments RN-L did. LPN-N informed Surveyor RN-L was listening to R3's lungs and asking him questions like how long he has felt like this, when did it start, did he want to go to the hospital. R3 said yes. That's all I believe I can recall. Surveyor asked LPN-N if she told RN-L what R3's oxygen saturation was. LPN-N replied yes. Surveyor asked LPN-N when she obtained an oxygen saturation of 65% for R3 why didn't she send R3 out to the hospital. LPN-N replied because I had to call the doctor. Usually, we have to get an order to send him out. Surveyor asked LPN-N if she was in R3's room prior to him placing on the call light. LPN-N replied, just to peek in. Surveyor asked LPN-N what she meant by peeking in. LPN-N informed Surveyor she checks to make sure the resident is not at the edge of the bed, positioning is good, bed is low, call light, things like that. Surveyor asked prior to R3 putting on his call light, had she taken R3's vital signs. LPN-N replied, I did not. Surveyor asked from the time she called for the ambulance, how long was it until they arrived. LPN-N replied 15 maybe 20 minutes seemed like they came pretty fast. Surveyor asked LPN-N who was the charge nurse this night. LPN-N replied I believe it was me but not positive. Surveyor asked who documents the assessments. LPN-N replied usually the RN puts their own note in. Surveyor asked if RN-L documented. LPN-N replied, I don't believe she did, no. Surveyor asked LPN-N if RN-L gave her any information to include in her note. LPN-N replied no, not that I'm aware of. Surveyor asked LPN-N after she received an oxygen sat for R3 of 65% how long was it until RN-L came to the unit. LPN-N replied maybe 5 minutes. Surveyor asked LPN-N if there was anything else she wanted Surveyor to know. LPN-N informed Surveyor she tried to put everything in her note. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN-N's nurses note is dated [DATE], at 02:12 (2:12 a.m.), documents Patient C/O (complained of) SOB (shortness of breath). TPR (temperature, pulse, respirations) 98.4, 97, 28. BP (blood pressure) ,d+[DATE]. SPO2 65%, RA (room air). O2 (oxygen) started at 2L (liters) and SPO2 remained at 65% so increased to 3L (liters) per NC (nasal cannula)/mask. Congested cough with tracheal congestion noted. LS (lung sounds) course with expiratory wheezes. HOB (head of bed) elevated. LPN (Licensed Practical Nurse) and RN (Registered Nurse) assessed. NP (Nurse Practitioner) notified and ok to send to [hospital initials] ER (emergency room) for evaluation. [Name] ambulance called. Emergency contact notified. [Name] ambulance here to transport to [hospital initials] ER. Report called to ER RN [Name]. This nurses note was written by LPN-N. LPN-N also had a nurses note dated [DATE], at 02:19 (2:19 a.m.) which documents: Blood sugar 222. Surveyor notes LPN-N was calling the NP, responsible party, ambulance company, and giving report to the receiving hospital while RN-L was gathering the necessary paperwork for R3's transfer, however, RN-L was called back to her assigned unit, leaving CNA-V with R3 who continued to experience a more severe change in condition as noted by BLS EMS's assessment of R3 upon their arrival. (continued on next page)

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	525359	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Ridge Health Services	2730 W Ramsey Ave Milwaukee, WI 53221

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 2:34 p.m., Surveyor interviewed RN (Registered Nurse)-L regarding R3. RN-L informed Surveyor she works the back half which consists of the 200 & 300 units. RN-L informed Surveyor R3 was having trouble breathing and [first name of LPN-N] asked her to give a 2nd opinion. RN-L stated his lungs were not sounding great. RN-L informed Surveyor when she went in, he was alert and talking with both of them, stated he was having trouble breathing and his O2 (oxygen) was mid to high 80s. RN-L informed Surveyor she couldn't remember the exact number. Surveyor asked RN-L if she did any assessment. RN-L informed Surveyor she listened to R3's lungs, they weren't clear and wasn't sure if they were coarse. RN-L informed Surveyor she told LPN-N, you're right something is going on. Surveyor asked RN-L if LPN-N told her what R3's oxygen saturation was. RN-L stated, she (LPN-N) got, like I said, mid to high 80s. Surveyor informed RN-L R3's oxygen saturation was 65%. RN-L replied, Sh*t I didn't know it was that low thought 85, 88. Surveyor then read LPN-N's [DATE] note which documented R3's oxygen at 65%. RN-L replied, Sh*t I would have called [name of medical group] if it was 65 and sent R3 out. RN-L informed Surveyor O2 at 85 (%) she's worried but at 65 (%) she's panicking. Surveyor asked who called [name of medical group]. RN-L informed Surveyor she doesn't remember. RN-L informed Surveyor she was trying to get the paperwork ready but was having trouble with the printer. Surveyor asked RN-L if she remembers what time LPN-N came to get her. RN-L informed Surveyor she doesn't remember any of the times. Surveyor asked RN-L if she documented her assessment. RN-L informed Surveyor usually she has a notebook in her pocket so she can write things down and tear it out. Surveyor asked RN-L if she gave LPN-N any information. RN-L informed Surveyor she assumes she did but can't swear she did. Surveyor asked RN-L if she was the supervisor this night. RN-L replied no they have not made me charge nurse and explained usually, the nurse on the 100 unit is the charge nurse, who was LPN-N, was the charge nurse. Surveyor asked who would document an assessment. RN-L informed Surveyor the nurse who has the resident. RN-L informed Surveyor the nurse who has the resident would do the change of condition, call [name of medical group] and all that stuff. Surveyor asked who documented on R3. RN-L replied just the LPN and stated she was getting everything ready. RN-L informed Surveyor while she was with LPN-N she got called back to her unit and when she went back to check on LPN-N, EMS (emergency medical services) was already in the room ready to load R3 up. Surveyor asked RN-L prior to LPN-N getting her, had she been told anything about R3. RN-L replied no, explaining she is usually on unit 3 and didn't know anything about R3. RN-L informed Surveyor when LPN-N came to get her she was charting at the nurses' station on her unit and asked her if she could borrow her. RN-L informed Surveyor she checked R3's breathing. Surveyor asked RN-L who determined to place 2 liters of oxygen on R3. RN-L replied she did. RN-L informed Surveyor they were partners in assessing if that makes sense. Surveyor asked RN-L again if she knew R3's oxygen was 65. RN-L replied, I didn't realize it was that low, thought she said 85, I must have misheard. 85 is worrying & 65 is panic and I panic. Did not know it was 65. According to https://my.clevlandclinic.org, Hypoxia can be life-threatening and if you are experiencing symptoms of hypoxia, call 911. Surveyor notes LPN-N's evaluation of R3 was miscommunicated and/or misunderstood by RN-L. RN-L did not complete and document an assessment of R3. BLS Ambulance Crew arrived at the facility and assessed R3 to be experiencing a more severe change in condition as they were unable to get blood pressure, a weak carotid bradycardic regularly irregular pulse at 58, SPO2 was approximately 70% on room air, bradypneic at approximately 8 for irregularly irregular respiration rate. Crew used BVM (Bag valve mask) with oxygen at 15 liters per min (minute). Surveyor reviewed the private ambulance Patient Care Report, dated [DATE], which documents: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Disp (dispatch) notified: 01:31(AM), [DATE] Recvd (received): 01:31 (AM), [DATE] En route: 01:31 (AM), [DATE] At scene: 01:37 (AM), [DATE] At patient: 01:38 (AM), [DATE] [NAME] (Transition of care): 01:45 (AM), [DATE] Crew 1 level: EMT-Basic Nature of the call: Respiratory Distress Unit type: BLS (Basic Life Support) Chief Complaint: Respiratory-Severe Distress (Primary) Primary Symptoms: Periodic Breathing; or Cheyne-Stokes Breathing (periods of shallow breathing alternating with periods of deeper, rapid breathing. The deep, rapid breathing may be followed by a pause before breathing begins again.); Abnormal breathing pattern. Assessment: [DATE], at 01:39 (AM), B/P (blood pressure) no; Pulse: 58, weak, regular; Respiratory: Weak, Agonal, irregularly irregular; SPO2 (oxygen saturation): 70% on room air. -Skin Temp-Cool; Skin color: Pale; Skin moisture: Clammy -Level of consciousness: Unresponsive, Arm Movement: Left-None, Right-None; Leg - Movement: Left-None, Right-none Treatment Summary: Time: 01:40 (AM): Oxygen -Device: Adult BVM (Bag Valve Mask) -Dosage Unites: Liters per Minute -Rate: 15 LPM (Liters per Minute) -Indication: Respiratory Failure -Response: Improved (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Successful: Yes Time: 01:42 (AM) Indication: Respiratory Distress Response: Unchanged SpO2: 85% Time: 01:46 (AM) -Blood Glucose Measurement: 222 -Response: Unchanged Narrative: [Name of Ambulance Company] dispatched no lights and sirens to address above (address of the Facility) for [AGE] year-old male patient for respiratory distress.Upon arrival crew was directed to patient room. Crew did not receive paperwork from health care staff, when brought up health care professional states staff was getting the paperwork now. Upon arrival patient was found in bed unconscious, crew obtaining vitals. Crew unable to get blood pressure. Crew obtained a weak carotid bradycardic regularly irregular pulse at 58. SPO2 was approximately 70% on room air. Patient was bradypneic at approximately 8 for irregularly irregular respiration rate. Crew used BVM with oxygen at 15 liters per min (minute). Crew was unable to get a [sic] adequate seal on the patients mouth due to the patient's bariatric status. Crew tried to get a summary of what happened. Healthcare professional that guided crew to patient stated she was not the person that took care of the patient and didn't know what was going on. Crew asked the healthcare professional to get the person that has information about the patient. Crew monitored patients SPO2 and heart rate. SPO2 improved with BVM and 15 liters of oxygen up to approximately 80%. Crew obtained blood glucose measurement at 222. ALS (Advanced Live Support/EMS) arrived on scene with healthcare professional in charge of patient. Crew transferred care to ALS. Crew assisted ALS due to poor seal of the BVM. ALS provided crew with CPAP (continuous positive air-way pressure) mask to put on patient as well. Crew assisted ALS with 12 lead. When put on patient was asystole (A condition where the heart's electrical and mechanical activity completely stops, resulting in a lack of a heartbeat.). Crew assisted ALS by providing chest compressions and breathing for patient with BVM at 15 liters per minute. Crew alternated positions to maintain adequate depth and speed for compressions. Crew proceeded to do CPR until instructed by ALS to stop due to med (medical) control pronouncing patient deceased . ALS (Advance Life Support) Ambulance Narrative, dated [DATE]: Assessment at 1:48 (AM): -Breathing: Absent: agonal (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Level of consciousness: unresponsive -Circulation: Pulses- Carotid-weak -Mental Status: Unresponsive [Name of private ambulance company] responded w/ (with) lights and sirens to the above location for respiratory distress. Crew arrived to discover an 85-y/o (year old) male PT (Patient) lying supine in bed assisted by SNF (Skilled Nursing Facility) staff, and [name of ambulance company number of BLS (Basic Life Support) crew] had been on the scene for a few minutes prior to (ALS)'s arrival, and immediately reported to crew that pt was in hypoxic shock due to inadequate ventilation PT had reportedly had severe bradynea at rate of ,d+[DATE] BPM on their arrival w/ thready pulses centrally and SPO2 measured ~60% on conventional device. Crew noted that pts skin was pale, cool, and dry. [BLS] had intervened immediately w/ BVM ventilation but were otherwise unable to intervene prior to [ALS]'s arrival. Staff indicated that PT had arrived [DATE] for rehabilitation of a recent procedure on the left hip. PT had reportedly exhibited severe lethargy and usually slow respiratory pattern approx. (approximately) 30 min (minutes) prior to EMS activation. PT's paperwork indicated PMH (Primary Medical History) of AKI (Acute Kidney Injury), primary hypertension, and Type 2 diabetes, w/ multiple antihypertensive and anticoagulants listed on the chart. Assessment was performed on scene. PT was found totally unresponsive/weak pulses noted in the carotid artery at ~30 BPM. Assessment from vitals was unsuccessful, as no numerical measurements were appreciable at [BLS] assessment. [DATE], at 01:57 (AM), Initial CPR: Attempted ventilation and initiated Chest Compressions. On [DATE], at 8:33 a.m., Surveyor called [name of medical group] to inquire who was the NP facility staff had contacted on [DATE]. NP-W informed Surveyor it was NP-Y and NP-W can email her as she doesn't have her phone number. On [DATE], at 9:02 a.m., Surveyor called [name of medical group] to try to speak with MD (Medical Doctor)-X. NP-W informed Surveyor MD-X is out on leave. Surveyor asked NP-W if she received a call from the facility telling her there is a new admission with oxygen sats at 65% what would she tell the nurse to do. NP-W replied call 911. NP-W informed Surveyor NP-Y works part time and wasn't working this day but could read Surveyor NP-Y's note. NP-W read to Surveyor NP-Y's note which read, nursing call request order ED for evaluation due to respiratory distress. Pt pulse ox 65% on 3L inspirations and expirations wheezing using accessory muscles. Nursing orders given. NP-W informed Surveyor NP-Y's note doesn't say to call 911. NP-W informed Surveyor this note was created on [DATE] at 2:16 a.m. On [DATE], at 9:15 a.m., Surveyor spoke with NP-W on the telephone along with Director of Operations-Z from [name of medical group] to inquire if NP-Y spoke with the facility when they called or if she had to call them back. Surveyor was informed the call from the facility came in at 1:18 a.m., the patient order given was time stamped at 2:16 a.m. for when it was created in the chart, but they don't know if NP-Y spoke to the facility at 1:18 a.m. or she had to call back. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 10:38 a.m., Surveyor spoke with DON (Director of Nursing)-B to inquire what the night shift staffing is. DON-B informed Surveyor there are 2 nurses and 3 to 4 CNAs. One nurse is on the 100 unit and the other nurses takes 2 & 3. Surveyor asked if there is a charge nurse. DON-B informed Surveyor the charge nurse is working on the 100 unit. Surveyor asked what happens when a resident has a change of condition. DON-B informed Surveyor they typically wait for an order if it's an emergency the nurse could use their judgement and send them out. Surveyor asked about oxygen orders. DON-B informed Surveyor there is a standard nursing order for 2 liters and then call the doctor if it needs to go up. Surveyor asked if an LPN is working the unit, and a resident has a change of condition what should be done. DON-B informed Surveyor the LPN should observe the findings what they see, call the RN in the building, the RN can assess, and if it's an emergency send them out. Surveyor asked about R3. DON-B informed Surveyor LPN-N came into the room to answer the call light, R3 was SOB, she called RN-L who came and assessed. DON-B informed Surveyor he was responsive, his O2 was 85, respirations were high, they called [name of medical group] and gave an order. Once the ambulance came, they took over. Surveyor asked DON-B if the RN does their own vital signs. DON-B replied, she said they were doing vitals together. Surveyor asked DON-B if a resident has O2 sats of 65 what would you expect staff to do. DON-B replied hope they called for ambulance and prepare for code. DON-B informed Surveyor personally she would have cranked up the oxygen. Surveyor asked DON-B if she was aware when LPN-N took R3's oxygen sats it was 65. DON-B replied no, not until I looked at the progress note. RN-L told me 85. Surveyor asked DON-B if the NP doesn't specifically say to call 911 could the nurse call 911. DON-B replied, I don't know what our policy is I'll have to get back to you. On [DATE], at 3:07 PM, Surveyor interviewed Deputy Director of Operations for the EMS ambulance company (DDO)-AA who stated BLS did report to ALS R3 was in hypoxic shock upon their arrival. The facility's failure to ensure R3 received appropriate care and treatment when R3 experienced a change in condition including shortness of breath, increased pulse and respirations, and low oxygen sats led to a finding of immediate jeopardy. The immediate jeopardy was removed on [DATE] when the facility implemented the following action plan: * Director of Nursing completed an audit of residents requiring transfer from facility to higher level of care within the last 14 days, to verify appropriate provider notification and Emergency Medical Services activation. [DATE] * Facility Licensed Nursing staff reeducated by Director of Nursing or designee on Change of Condition of the Resident policy starting [DATE] and will be completed prior to next scheduled shift. This re-education included information on assessing (done by the RN if available) or data gathering (done by the LPN) and reporting findings requiring immediate notification to the medical provider. Re-education includes use of the INTERACT 4.5 Change in Condition Guidelines for when to immediately notify the physician/provider. Reeducation also includes when to activate Emergency medical services by calling 911 for residents requiring emergency intervention. * The Director of Nursing, Executive Director, and [NAME] President of Success reviewed established Change in condition of resident policy. No changes were necessary to this policy. [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Director of Nursing or Designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of change of condition and notification of provider including method of transfer and if 911 contacted or ambulance service contacted. These audits will be completed daily 2 weeks, then with morning clinical 5 days per week for 10 weeks or until substantial compliance is maintained. Results of these audits will be brought to QAPI (quality assurance performance improvement) for review and recommendation. * ADHOC QAPI review of this plan was completed with Medical Director, VP (Vice President) of Success, Director of Nursing, and Executive Director. [DATE] The deficient practice continues at a scope/severity of D (harm/isolated) as evidenced by the following example with R1. 2.) R1's diagnoses includes atherosclerotic heart disease, chronic kidney disease, and hypertension. The physician