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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 12/8/22 through 12/20/22. One (1) complaint (VA00057069 - substantiated with deficiencies) was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. A past non-compliance immediate jeopardy was cited at F695. The citation was lowered to a D. The census in this 56 certified bed facility was 51 at the time of the survey. The survey sample consisted of six (6) current resident reviews and two (2) closed record reviews.	F 000		
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, document review, and in the course of a complaint investigation, the facility staff failed to provide respiratory therapy care and services to address the needs of four (4) of eight (8) sampled residents with ventilator orders (Resident #1, Resident #2, Resident #3, and Resident #4). For Resident #1, On 12/19/2 at 3:50 P.M., Immediate Jeopardy-Past Noncompliance was called, and	F 695	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 01/17/2023

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lowered to a D.

The findings include:

1. The facility staff failed to implement Resident #1's medical provider's ventilator orders to ensure the resident was provided the necessary ventilation and oxygen. The facility staff failed to ensure Resident #1's ventilator care and/or ventilator assessments were appropriately completed by a respiratory therapist (RT). The facility staff failed to ensure Resident #1's remote ventilator alarm was turned on when the resident's ventilator was in use. (The remote ventilator alarm is a supplemental alarm used in addition to the alarms built into the ventilator. The remote alarm was located near the top of the door, in the hallway, outside Resident #1's room.)

Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/8/22, was dated as completed on 11/22/22. Resident #1 was assessed as able to make self understood and as able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15 (indicating intact and/or borderline cognition). Resident #1 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #1's diagnoses included Respiratory Failure. Resident #1 was documented as receiving oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator use.

Resident #1's medical provider orders included:
- Settings for ventilator use related to "CHRONIC RESPIRATORY FAILURE WITH HYPOXIA"

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dated 11/16/22 and
- "(tracheostomy collar) trials 4 (hours two times a day) and with (physical therapy) increase (oxygen) to 10 (liters) and with (Passy Muir Valve) two times a day for WEANING related to DEPENDENCE ON RESPIRATORY [VENTILATOR] STATUS" dated 11/28/22.

The facility policy and procedure titled "Passy-Muir Valve" (this document was not dated) indicated its use was the basic responsibility of respiratory therapist (RT) and/or speech therapist (ST). This documented stated the "purpose of the Passy-Muir Valve (PMV) is to aid in the weaning of a resident from an artificial airway and facilitate communication."

The facility policy/procedure titled "Ventilator Management" (this document was not dated) provided the following information: "All ventilators that are in a resident room will be connected to an external audible alarm."

Resident #1's care plan included a focus of "resident is ventilator dependent via tracheostomy secondary to respiratory failure". This care planned focus included the following interventions: administer oxygen as ordered, respiratory therapy as ordered, ventilator setting per order, and weaning protocol as indicated.

On 12/8/22 at 1:25 p.m., the surveyor interviewed the facility's Administrator about Resident #1 being found unresponsive on the evening of 12/6/22. The Administrator stated it was determined that Resident #1 was removed from the ventilator on 12/6/22 at 9:44 a.m. by Respiratory Therapist (RT) #2 for a weaning trial/trach collar trial. The Administrator reported

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RT #2 stated they had placed Resident #1 back on the ventilator on 12/6/22 at 6:10 p.m. The Administrator acknowledged Resident #1's weaning trial/trach collar trial and the reported return to the ventilator had not been documented. The Administrator reported, that at approximately 7:30 p.m. on 12/6/22, RT #1 found Resident #1 unresponsive while doing rounds.

On 12/8/22 at 5:48 p.m., Respiratory Therapist (RT) #1 was interviewed about finding Resident #1 unresponsive on the evening of 12/6/22. RT #1 confirmed they found Resident #1 unresponsive on the evening of 12/6/22, at approximately 7:30 P.M. RT #1 reported, when they entered Resident #1's room, they knew something was wrong. RT #1 stated they asked Resident #1 if they needed anything, but the resident did not respond. RT #1 stated Resident #1 was "extremely cold." RT #1 reported Resident #1 was found connected to the ventilator, but the ventilator was in "standby" and wasn't providing respirations. RT #1 reported they turned the ventilator on and went to yell for help. RT #1 reported when they turned the ventilator on it appeared as if it was working properly. RT #1 reported basic life support, including the use of an automated external defibrillator (AED), was provided. RT #1 reported Resident #1 was not revived.

On 12/9/22 at 10:10 a.m., Respiratory Therapist (RT) #2 was interviewed, via telephone, about the event referenced in this complaint. RT #2 had provided care for Resident #1 during dayshift (7AM - 7PM) on 12/6/22. RT #2 reported it was a typical day. RT #2 stated Resident #2 completed the second weaning trial / trach collar trial at approximately 6:00 p.m. on 12/6/22. RT #2

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stated they placed Resident #2 back on the ventilator. RT #2 reported the ventilator was working; RT #2 reported Resident #1's heart rate was in the 70s and the resident's oxygen saturation was in the upper 90%. RT #2 stated they suctioned Resident #1 twice; RT #2 stated it was not deep suctioning. RT #2 reported they left Resident #2's rooms to respond to a resident calling-out from another room. When asked if they turned on the ventilator alarm located outside Resident #1's room, RT #2 stated, "I believe I did not."

On 12/8/22 at 1:37 p.m., the facility's Administrator and Director of Respiratory were asked for copies of Resident #1's ventilator machine data reports. The facility staff was able to provide a report of some of the internal data from Resident #1's ventilator. The facility staff was unable to provide guidance to explain the information retrieved from the ventilator's internal data. The data obtained from Resident #1 ventilators was reviewed for evidence of ventilator use at the following times: on 12/6/22 at approximately 6:10 p.m. and on 12/6/22 at approximately 7:30 p.m. The information provided to the surveyor from the ventilators internal data was not clear about ventilator use at the aforementioned times. Resident #1's ventilator was being sent to the manufacture for further evaluation.

On 12/15/22 at 9:08 a.m., the surveyor reviewed Resident #1's respiratory care documentation with the facility's Director of Respiratory. The following issues were identified:
- On 12/1/22's 7AM dayshift, Resident #1's respiratory documentation failed to include (a) a progress note for when the resident was placed

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on a weaning trial / trach collar trial and (b) a ventilator check assessment when the resident was placed back on the ventilator after the conclusion of the weaning trial / trach collar trial. The Director of Respiratory reported the facility did not have a policy and/or procedure detailing the documentation of weaning trials/trach collar trials. The Director of Respiratory reported a progress note should have been documented when the weaning trial/trach collar trial was initiated and that a ventilator check assessment should have been completed when the ventilator was restarted after the conclusion of the weaning trial/trach collar trial.

- On 12/2/22's 7AM dayshift, Resident #1's respiratory documentation failed to provide evidence of a respiratory therapist providing the weaning trial/trach collar trial; documentation of the weaning trial/trach collar trial was documented by a licensed practical nurse (LPN). The Director of Respiratory reported a respiratory therapist should have provided the weaning trial/trach collar trial and a respiratory therapist should have completed a ventilator check assessment at the time the resident was placed back on the ventilator after the weaning trial/trach collar trial.
- On 12/2/22's 7PM nightshift, Resident #1's respiratory administration record (RAR) indicated the resident's weaning trial/trach collar trial was not provided as ordered. The Director of Respiratory confirmed there was no documentation to indicate the weaning trial/trach collar trial had been provided. The Director of Respiratory reported a reason for not providing the weaning trial/trach collar trial had not been documented.
- On 12/3/22's 7AM dayshift, Resident #1's respiratory documentation failed to include (a) a

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progress note for when the resident was placed on a weaning trial/trach collar trial and (b) a ventilator check assessment when the resident was placed back on the ventilator after the conclusion of the weaning trial/trach collar trial. The Director of Respiratory reported a progress note should have been documented when the weaning trial/trach collar trial was initiated and that a ventilator check assessment should have been completed when the ventilator was restarted after the conclusion of the weaning trial/trach collar trial.
- On 12/4/22's 7AM dayshift, Resident #1's respiratory documentation failed to include (a) a progress note for when the resident was placed on a weaning trial/trach collar trial and (b) a ventilator check assessment when the resident was placed back on the ventilator after the conclusion of the weaning trial/trach collar trial. The Director of Respiratory reported a progress note should have been documented when the weaning trial/trach collar trial was initiated and that a ventilator check assessment should have been completed when the ventilator was restarted after the conclusion of the weaning trial/trach collar trial.
- On 12/5/22's 7AM dayshift, Resident #1's respiratory documentation failed to include (a) a progress note for when the resident was placed on a weaning trial/trach collar trial and (b) a ventilator check assessment when the resident was placed back on the ventilator after the conclusion of the weaning trial/trach collar trial. The Director of Respiratory reported a progress note should have been documented when the weaning trial/trach collar trial was initiated and that a ventilator check assessment should have been completed when the ventilator was restarted after the conclusion of the weaning trial/trach

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collar trial.
- On 12/5/22's 7PM nightshift, Resident #1's respiratory progress note, timed 7:05p.m., indicated the resident's weaning trial/trach collar trial was not provided due to both weaning trials/trach collar trials had been provided during the dayshift. The Director of Respiratory confirmed there was no documentation indicating both of the provider ordered weaning trials/trach collar trials had been provided during the dayshift.

On 12/8/22 at 1:42 p.m., the facility's Director of Respiratory reported all respiratory staff had been in-serviced related to ventilator care or will receive in-service training prior to being allowed to work their next shift. Documentation of the respiratory staff training, dated 12/7/22, was provided to the surveyor prior to the conclusion of the survey. All other residents on ventilators were observed to receive oxygen per physician's order during each day of the survey.

The facility staff began every 30-minute monitoring the external ventilator alarms on 12/9/22. This monitoring was ongoing and was planned to be continued until reviewed by the facility's quality assurance and performance improvement (QAPI) committee. Documentation of the 30-minute external ventilator monitoring was provided to the surveyor.

The facility's respiratory care department implemented mandatory walking rounds/report on 12/7/22. The facility's Director of Respiratory provided the surveyor with evidence of respiratory staff communication of the mandatory walking rounds/report dated 12/7/22. Interviews with current respiratory staff members confirmed walking rounds/report were occurring at change

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of shift.

On the morning of 12/20/22, the facility's Administrator reported the facility's quality assurance and performance improvement (QAPI) committee will review any identified respiratory issues during the upcoming QAPI meeting.

This is a complaint deficiency.

2. The facility staff failed to ensure Resident #2's ventilator assessments were completed by a respiratory therapist (RT) at the appropriate times. The Director of Respiratory, on 12/9/22 at 8:40 a.m., provided a copy of a document titled "DAILY ROUNDS". This document indicated ventilator assessments were to be completed at least twice per 12-hour shift.

Resident #2's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/9/22, was dated as completed on 9/23/22. Resident #2 was assessed as able to make self understood and as able to understand others. Resident #2's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15 (indicating intact and/or borderline cognition). Resident #2 was assessed as being independent with bed mobility, dressing, eating, and toilet use. Resident #2 was assessed as requiring supervision with transfers and personal hygiene. Resident #2's diagnoses included Respiratory Failure. Resident #2 was documented as receiving oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator use.

Resident #2's medical provider orders included an order dated 9/7/22 for the use of a mechanical

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ventilator. Resident #2's care plan included a focus of "(resident name omitted) is ventilator dependent via tracheostomy secondary to respiratory failure".

The facility policy/procedure titled "Ventilator Management" (this document was not dated) provided the following information:
- The policy stated it was the basic responsibility of the respiratory therapist.
- Under the heading of "Procedure" were the following steps: "1. Verifies physician order. 2. Washes hands, maintains standard precautions. 4. [sic] Obtains appropriate supplies/equipment. 5. Identifies resident, explains procedure, and provides privacy. 6. Properly assembles supplies/equipment. 7. Perform operational check. a. If ventilator fails operational check pull from service and place defective sticker. 8. Adjust ventilator to prescribed settings. 9. Connect ventilator to resident. 10. Confirm PEEP valve set to correct setting 11. Analyze FI02. 12. Assess resident respiratory status. (HR, RR, BBS, SP02) 13. If new admission perform ETC02 analysis. 14. Document".
- Under the heading of "Documentation" were the following items: "1. Date and time of procedure. 2. Ventilator settings. 3. Resident respiratory status. 4. Resident response to therapy 3. [sic] Signature."

On 12/19/22 at 12:31, the facility's Administrator, ADON, and Director of Respiratory were interviewed about LPN monitoring of ventilator care and/or weaning trials/trach collar trials. It was reported that the facility did not have a written policy and/or procedure detailing LPN responsibility in monitoring ventilator care and/or weaning trials/trach collar trials.

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The facility's Director of Respiratory and the surveyor reviewed Resident #2's clinical documentation on the 12/20/22 at 9:14 a.m. It was noted that only one (1) ventilator assessment was completed for the 7AM - 7PM shift on 12/6/22. Respiratory Therapist (RT) #3 was documented as completing a ventilator assessment on 12/6/22 at 8:08 a.m. RT #3's time clock records indicated they (RT #3) was not working at the time of the aforementioned ventilator assessment. The Director of Respiratory reported the ventilator assessment should have been completed by one of the respiratory therapists working at the time the ventilator assessment was due. The Director of Respiratory reported two (2) ventilator assessments should have been completed during the 7AM - 7PM shift on 12/6/22.

RT #3 was interviewed via telephone on 12/13/22 at 7:05 p.m. RT #3 reported, when they came in early on the afternoon of 12/6/22, they were instructed by other respiratory staff members to document resident information collected by a licensed practical nurse (LPN) who was working as part of the respiratory staff. RT #3 stated they documented the information collected by the LPN. RT #3 stated they contacted the Director of Respiratory, on 12/6/22, because they (RT #3) had been uncomfortable with documenting the information collected by the LPN.

On 12/20/22 at 10:10 a.m., the survey team met with the facility's Administrator and Director of Respiratory. RT #3 documenting information collected by an LPN and only one (1) ventilator assessment being completed on 12/6/22 dayshift was discussed during this meeting.

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3. The facility staff failed to ensure Resident #3's ventilator assessments were completed by a respiratory therapist (RT) at the appropriate times. The Director of Respiratory, on 12/9/22 at 8:40 a.m., provided a copy of a document titled "DAILY ROUNDS". This document indicated ventilator assessments were to be completed at least twice per 12-hour shift.

Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/11/22, was dated as completed on 10/24/22. Resident #3 was assessed as able to make self understood and as able to understand others. Resident #3's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15 (indicating intact and/or borderline cognition). Resident #3 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #3's diagnoses included Respiratory Failure. Resident #3 was documented as receiving oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator use.

Resident #3's medical provider orders included an order dated 8/24/22 for the use of a mechanical ventilator. Resident #3's care plan included a focus of "resident is ventilator dependent via tracheostomy secondary to respiratory failure ..."

The facility policy/procedure titled "Ventilator Management" (this document was not dated) provided the following information:
- The policy stated it was the basic responsibility of the respiratory therapist.

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- Under the heading of "Procedure" were the following steps: "1. Verifies physician order. 2. Washes hands, maintains standard precautions. 4. [sic] Obtains appropriate supplies/equipment. 5. Identifies resident, explains procedure, and provides privacy. 6. Properly assembles supplies/equipment. 7. Perform operational check. a. If ventilator fails operational check pull from service and place defective sticker. 8. Adjust ventilator to prescribed settings. 9. Connect ventilator to resident. 10. Confirm PEEP valve set to correct setting 11. Analyze FI02. 12. Assess resident respiratory status. (HR, RR, BBS, SP02) 13. If new admission perform ETC02 analysis. 14. Document".
- Under the heading of "Documentation" were the following items: "1. Date and time of procedure. 2. Ventilator settings. 3. Resident respiratory status. 4. Resident response to therapy 3. [sic] Signature."

On 12/19/22 at 12:31, the facility's Administrator, ADON, and Director of Respiratory were interviewed about LPN monitoring of ventilator care and/or weaning trials/trach collar trials. It was reported that the facility did not have a written policy and/or procedure detailing LPN responsibility in monitoring ventilator care and/or weaning trials/trach collar trials.

The facility's Director of Respiratory and the surveyor reviewed Resident #3's clinical documentation on the 12/20/22 at 9:27 a.m. It was noted that only one (1) ventilator assessment was completed for the 7AM - 7PM shift on 12/6/22. Respiratory Therapist (RT) #3 was documented as completing a ventilator assessment on 12/6/22 at 8:55 a.m. RT #3's time clock records indicated they (RT #3) was not

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working at the time of the aforementioned ventilator assessment. The Director of Respiratory reported the ventilator assessment should have been completed by one of the respiratory therapists working at the time the ventilator assessment was due. The Director of Respiratory reported two (2) ventilator assessments should have been completed during the 7AM - 7PM shift on 12/6/22.

RT #3 was interviewed via telephone on 12/13/22 at 7:05 p.m. RT #3 reported, when they came in early on the afternoon of 12/6/22, they were instructed by other respiratory staff members to document resident information collected by a licensed practical nurse (LPN) who was working as part of the respiratory staff. RT #3 stated they documented the information collected by the LPN. RT #3 stated they contacted the Director of Respiratory, on 12/6/22, because they (RT #3) had been uncomfortable with documenting the information collected by the LPN.

On 12/20/22 at 10:10 a.m., the survey team met with the facility's Administrator and Director of Respiratory. RT #3 documenting information collected by an LPN and only one (1) ventilator assessment being completed on 12/6/22 dayshift was discussed during this meeting.

4. The facility staff failed to ensure Resident #4 had two (2) ventilator assessments completed on 12/6/22 during the dayshift (7AM - 7PM). The Director of Respiratory, on 12/9/22 at 8:40 a.m., provided a copy of a document titled "DAILY ROUNDS". This document indicated ventilator assessments were to be completed at least twice per 12-hour shift.

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Resident #4's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/14/22, was dated as completed on 11/28/22. Resident #4 was assessed as rarely and/or never able to make self understood and as rarely and/or never able to understand others. Resident #4 was documented as having severely impaired cognitive skills for daily decision making. Resident #4 was assessed as being dependent on others for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Resident #4's diagnoses included Respiratory Failure. Resident #4 was documented as receiving oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator use.

Resident #4's medical provider orders included an order dated 9/28/22 for the use of a mechanical ventilator. Resident #4's care plan included a focus of "resident is ventilator dependent via tracheostomy secondary to respiratory failure".

The facility policy/procedure titled "Ventilator Management" (this document was not dated) provided the following information:
- The policy stated it was the basic responsibility of the respiratory therapist.
- Under the heading of "Procedure" were the following steps: "1. Verifies physician order. 2. Washes hands, maintains standard precautions. 4. [sic] Obtains appropriate supplies/equipment. 5. Identifies resident, explains procedure, and provides privacy. 6. Properly assembles supplies/equipment. 7. Perform operational check. a. If ventilator fails operational check pull from service and place defective sticker. 8. Adjust ventilator to prescribed settings. 9.

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Connect ventilator to resident. 10. Confirm PEEP valve set to correct setting 11. Analyze FI02. 12. Assess resident respiratory status. (HR, RR, BBS, SP02) 13. If new admission perform ETC02 analysis. 14. Document".
- Under the heading of "Documentation" were the following items: "1. Date and time of procedure. 2. Ventilator settings. 3. Resident respiratory status. 4. Resident response to therapy 3. [sic] Signature."

On 12/19/22 at 12:31, the facility's Administrator, ADON, and Director of Respiratory were interviewed about LPN monitoring of ventilator care and/or weaning trials/trach collar trials. It was reported that the facility did not have a written policy and/or procedure detailing LPN responsibility in monitoring ventilator care and/or weaning trials/trach collar trials.

The facility's Director of Respiratory and the surveyor reviewed Resident #4's clinical documentation on the 12/20/22 at 9:35 a.m. It was noted that no ventilator assessments were completed for the 7AM - 7PM shift on 12/6/22. Respiratory Therapist (RT) #3 was documented as completing a respiratory assessment on 12/6/22 at 8:30 a.m. RT #3's time clock records indicated they (RT #3) was not working at the time of the aforementioned respiratory assessment. The Director of Respiratory reported two (2) ventilator assessments should have been completed during the 7AM - 7PM shift on 12/6/22.

RT #3 was interviewed via telephone on 12/13/22 at 7:05 p.m. RT #3 reported, when they came in early on the afternoon of 12/6/22, they were instructed by other respiratory staff members to

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F 695	Continued From page 16 document resident information collected by a licensed practical nurse (LPN) who was working as part of the respiratory staff. RT #3 stated they documented the information collected by the LPN. RT #3 stated they contacted the Director of Respiratory, on 12/6/22, because they (RT #3) had been uncomfortable with documenting the information collected by the LPN. On 12/20/22 at 10:10 a.m., the survey team meet with the facility's Administrator and Director of Respiratory. RT #3 documenting information collected by an LPN and no ventilator assessment being completed on 12/6/22 dayshift was discussed during this meeting.	F 695		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		1/9/23

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§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and

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F 842	Continued From page 18 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews, facility document review, and in the course of a complaint investigation, the facility staff failed to maintain complete and accurate clinical documentation for one (1) of eight (8) sampled residents (Resident #1). The findings include: Resident #1's clinical documentation failed to include the use of an automated external defibrillator (AED) when attempting to resuscitate the resident. Resident #1's clinical documentation included progress notes by a respiratory therapist (RT) whose electronic signature incorrectly identified the RT as a licensed practical nurse (LPN). Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/8/22, was dated as completed on 11/22/22. Resident #1 was assessed as able to make self understood and as able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15 (indicating intact and/or borderline cognition). Resident #1 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #1's diagnoses included Respiratory Failure. Resident #1 was documented as receiving oxygen therapy, suctioning, tracheostomy care, and invasive	F 842	Resident #1 expired 12/6/22. Facility determined that all residents could be affected by deficient practice. Staff in-service for RN,LPN, RT on appropriate AED documentation will be completed by 1/9/2023. Audit will be completed by management staff on Code Blue/AED documentation 5 times a week starting 1/4/2023 for eight weeks. Will reevaluate at eight weeks and continue random audits thereafter. Audit will be completed for all newly hired Respiratory Therapy staff to ensure correct credentials have been assigned for Point Click Care documentation. Human Resources will include Administrator on User Access Change form sent to IT department for accuracy of credentials. All corrective action completed by 1/9/2023.	

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mechanical ventilator use.

On 12/8/22 at 5:48 p.m., Respiratory Therapist (RT) #1 was interviewed about the care Resident #1 was provided when found unresponsive. RT #1 reported the facility staff applied the AED to Resident #1, but shock was not advised. RT #1 reported facility staff continued with CPR until Emergency Medical Services (EMS) arrived.

On 12/19/22 at 1:02 p.m., the facility's Administrator stated the nurse who was providing care for Resident #1 should have documented the use of the AED in the resident's clinical record.

Review of Resident #1's clinical record revealed RT #2 included multiple progress notes with an electronic-signature that identified RT #2 as a licensed practice nurse (LPN) instead of a respiratory therapist (RT). On 12/15/22 at 9:06 a.m., Staff Member (SM) #8 (a human resource employee) confirmed RT #2's information had been entered incorrectly into the facility's electronic records system resulting in the individual being incorrectly identified as an LPN.

On 12/20/22 at 10:10 p.m., the survey team interviewed the facility's Administrator and Director of Respiratory. The Administrator and the Director of Respiratory confirmed the facility did not have a written policy and/or procedure to address general documentation topics (e.g., accuracy, timing, late entries, and corrections). Resident #1's clinical documentation failing to include the use of an automated external defibrillator (AED) was discussed. RT #2's electronic signature identifying them (RT #2) as a licensed practical nurse (LPN) instead of a

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F 842	Continued From page 20 respiratory therapist (RT) was discussed.	F 842		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility staff failed to ensure the facility's ventilators were maintained according to manufactures guidance for 36 of the 36 ventilators located at the facility. The findings include: Review of ventilator maintenance documents failed to provide evidence of the monthly changing of the ventilators "air-inlet foam filter". The following information was found in the "Clinical Manual" for the type of ventilators used by the facility: "The air-inlet foam filter is the gray foam located on the back panel. It protects (ventilator) from dirt and dust. In the clinical environment, replace monthly and between patients." On 12/19/22 at 1:45 p.m., the Director of Respiratory reported the facility staff had not been completing the routine monthly changing of air-inlet foam filter. The Director of Respiratory reported the filters would have been changed when observed to be dirty. No documentation of the changing of the ventilators' air-inlet foam filters was provided to the surveyor.	F 908	On 12/15/2022 all ventilator filters were changed by contracted provider. Facility determined that all ventilator residents could be affected by deficient practice. In-service the dedicated Respiratory Therapist on filter changes monthly and the required documentation for filter changes. Completion on In-service was completed on 1/4/2023. Director of Respiratory will audit the completion of filter changes and documentation each month for three months. Will reevaluate at three months and continue random audits thereafter. All corrective action completed by 1/4/2023.	1/4/23

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F 908	Continued From page 21 On 12/20/22 at 10:10 a.m., the survey team meet with the facility's Administrator and Director of Respiratory. The failure of facility staff to change the facility's ventilators' air-inlet foam filters as detailed in the ventilators' "Clinical Manual" was discussed. The Administrator and the Director of Respiratory reported there was no policy and/or procedure to guide the changing of the aforementioned ventilator air-inlet foam filters; it was reported the facility staff would follow manufacturer's guidance. The administrative staff reported an individual from the equipment supply company changed the air-inlet foam filters on all the facility's ventilators on 12/15/22.	F 908		