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	165173	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE REHAB AND HEALTH CARE CENTER	**830 SOUTH FIFTH STREET OSAGE, IA 50461**

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F 000	INITIAL COMMENTS Correction date: 8/20/2024 The Osage Rehab and Health Care Center is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written during a complaint survey regaring intake #121931-C conducted July 12, 2024 thru July 17, 2024 Total Census: 33	F 000	The Plan on Correction does not constitute an admission or agreement by Osage Rehab and Health Care Center of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Osage Rehab and Health Care Center credible allegation of compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656	F 656 1. Resident #2 discharged on 6/28/2024 2. An audit will be completed on or before 08/15/24 by the DON/Designee to validate care plans interventions are current related to enteral intake to include HOB to be elevated with feedings and medication administration. 3. Education was provided to the licensed nurses related to care plans and implementation of the care plan for enteral feedings on 7/16/2024. 4. An audit will be completed by the DON or Designee monthly for 3 months to ensure enteral diets with tube feedings and elevation of HOB continues to be updated on the care plan as required. The results of these audits will be presented to the QAPI committee monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow-up as needed. Compliance date:8/20/2024	8/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Chris E. Bly

TITLE: Administrator

(X6) DATE: 08/17/2024

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

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findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility policy review, the facility failed to follow the Care Plan for 1 of 3 residents reviewed (Resident #2). The facility identified a census of 33 residents.

Findings included:

The Care Plan Focus dated 5/16/23 indicated Resident #2 required a feeding tube related to a swallowing problem. The Interventions directed the following:
a. Dependent on staff with tube feedings and water flushes.
b. Monitor, document and report to the Physician as needed (PRN) for the following: Aspiration, shortness of breath (SOB), abnormal breath/lung

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sounds and nausea and vomiting.
c. Resident #2 required the head of bed (HOB) elevated 45 degrees during and thirty minutes after a tube feeding.

During an interview on 7/15/24 at 2:27 PM Staff C, Certified Nursing Assistant (CNA), indicated Staff B, Registered Nurse (RN), came to her and reported Resident #2 just threw up and she needed assistance to reposition him. When the staff members entered Resident #2's room, they found him responsive (able to react) but lethargic (excessive tiredness). Resident #2 requested to elevate his left arm so the staff members repositioned him up further in the bed and elevated his arm on a pillow. Staff C confirmed Resident #2's had his HOB at approximately 15 degrees and he threw up.

During an interview on 7/15/24 at 1:23 PM Staff A, Licensed Practical Nurse (LPN), indicated on 6/28/24 around 1:50 PM or 1:55 PM, Staff B came to him and said she planned on not administering Resident #2's medications because he threw. Staff A asked Staff B if he was OK, and she indicated he was fine. So, Staff A stated he would go talk to him. At approximately 2:05 PM, Staff A entered Resident #2's room he observed Resident #2 positioned in a supine position with his head on a pillow, tube feeding formula draining from his nose, and Resident #2 non responsive.

A County Emergency Medical Services (EMS) Patient Care Report indicated the facility called the EMS crew at 2:55 PM with an arrival time of 3:00 PM. The EMS crew found Resident #2 lying in bed basically unresponsive but made noises when moved. The EMS crew's general

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F 656	Continued From page 3 impression of Resident #2 reflected him as an elderly man with Parkinson's and severe contractures. The staff reported they went to feed Resident #2 and he vomited. Resident #2 had a feeding tube and couldn't eat. Resident #2 had a temperature (T) of 104 degrees Fahrenheit (F). The crew transferred the patient to the gurney and transported him to the County Regional Hospital at 3:21 PM. During an interview on 7/15/24 at 3:57 PM one of the EMS crew members that responded to the call, confirmed when they arrived on the scene, they found Resident #2 lying in a supine position. The EMS crew member reported they found him in bed like that before, and that wasn't the first time they found him in the supine position when they arrived to transport him. The crew member verbalized concern over Resident #1's position.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy review, the facility failed to complete thorough assessments and interventions for a 2 of 3 residents following a condition change (Residents #1 and #2). The	F 684	F684 1. Resident #1 was reviewed related to follow up interventions related to wheezing and cough. Resident # 2 discharged from the facility on 6/28/2024. 2. The DON/Designee will complete an audit by 8/15/24 to ensure that any change of condition has follow up documentation in the medical chart and any concerns identified will be addressed at the time of the audit. 3. The DON/Designee educated licensed nurses on 7/16/2024 regarding the requirements of focused charting on change of conditions. 4. The DON/Designee will audit weekly for 4 weeks, then monthly for 2 months to ensure that focused charting continues to be completed on change of conditions. Results of the audits will be taken to the QAPI meeting monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow-up as needed. Date of compliance: 8/20/2024	8/20/2024

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facility identified a census of 33 residents.

Findings include:

1. Resident #2's Progress Notes dated 6/27/24 reflected the following at:
a. 6:09 AM Staff changed Resident #2's catheter per his request due to it bothering him. The nurse changed the catheter and noted some blood after placement.
b. 7:28 PM Blood noted in the catheter drainage bag

Resident #2's Progress Notes lacked assessments on his catheter between 6:09 AM and 7:28 PM. In addition, his record lacked additional assessments after 7:28 PM until his discharge to the hospital on 6/28/24 at 3:00 PM.

The Hospital's History of Present Illness report dated 6/28/24 indicated Resident #2 presented from the emergency department (ED) of an outlying facility for septic shock. The nursing facility found him unresponsive, covered with vomit, and running high fever of 104. This prompted an immediate transfer to the local ED. The last time they reported him as well at 10 AM on 6/28/24. He moaned to verbal and painful stimuli. His blood pressure on arrival at the outlying facility ED was 60s systolic (average systolic blood pressure 120), they gave 2 liters (L) of normal saline fluid bolus, but due to his persistent hypotension (low blood pressure), they started peripheral Levophed (medication used to increase blood pressure). His chest x-ray showed multiple patches likely concerning for aspiration pneumonia (infection caused by breathing particulates into the lungs. The nursing home reported Resident #2 had a blocked indwelling

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catheter, his bladder scan showed greater than 920 milliliters (ml), the ED flushed the catheter. "Chocolate milk-like" fluid returned after the flush. The ED gave him one dose of vancomycin (antibiotic), Zosyn (antibiotic), DuoNeb (nebulizer treatment to open the lungs), started on 6 L of high flow nasal cannula, and transferred him to a larger hospital for further management. Upon arrival to the critical care unit (CCU), Resident #2 noted unresponsive with a Glasgow coma score (GCS) of 4 (indicative of severe traumatic brain injury), fever of 102, blood pressure of 68/34 systolic (average 120/80) on 30 of Levophed and started vasopressin (medication used to increase blood pressure) and emergently intubated him. The team had difficultly intubating Resident #2 due to an enlarged tongue, when the team tried to intubate, his oxygen saturation dropped to 38% (expected greater than 90%). The team removed the laryngoscope (equipment used to visualize the throat while intubating a person) and bagged him with an Ambu bag (medical equipment used to breathe for a person), his oxygen saturation improved to 90%. During that time, Resident #2 had bilious vomitus (green or yellow vomit) coming out of his mouth. The team attempted to intubate with a D blade (curved intubation equipment), successfully. The team completed a bronchoscopy to suction out the vomitus from the lungs. The team started a central access and then started on broad-spectrum antibiotics.

During an interview on 7/15/24 at 12:34 PM Staff E, Licensed Practical Nurse (LPN) confirmed the day prior to Resident #2's transfer to the hospital she changed Resident #2's catheter per his request. The procedure occurred without incident except for some blood in the urine return which was normal for him. Resident #2's Physician

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performed rounds that day and directed the facility staff to monitor the blood in Resident #2's urine/catheter bag.

2. Resident #1's Minimum Data Set (MDS) assessment dated 5/17/24 included diagnoses of cerebral palsy, epilepsy, gastrostomy tube (g tube) and oropharyngeal phase dysphagia (difficulty swallowing).

The Health Status Note dated 6/14/24 at 2:37 PM indicated Resident #1 had a non productive cough that morning with wheezes to all of his upper lobes anteriorly (front).

An undated Guidelines for Hot Rack Documentation form directed the staff if a resident exhibited blood in their urine, the staff must document the following for 24 hours post 24 hours with no symptoms:
a. Vitals (blood pressure, pulse, respirations, and temperature).
b. How much blood.
c. When the bleeding started.
d. Description of urine.
e. Associated nausea and vomiting
f. Abdominal pain, cramping and distention
g. Presence/absence of hemorrhoids.

For breathing dyspnea (difficulty breathing):
a. Vitals
b. Wheezing or shortness of breath on exertion/shortness of breath when lying down relieved by sitting up.
c. Edema of lower extremities.
d. Chest pain/cough
e. Frequency and duration of symptoms.
f. Onset: sudden, respiratory distress and severe congestion.

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F 684	Continued From page 7 g. Hyperventilation (fast breathing greater than 20 breaths per minute), possible emotional causes. h. Cyanosis (low blood oxygen levels) /Oxygen (O2) saturations/oxygen administered and how much. i. Associated pertinent diagnosis/history. j. Physician/family notification.	F 684		
F 693 SS=J	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, Physician interview, Emergency Medical Service (EMS) interview, and facility policy review, the facility failed to provide adequate care and	F 693	F693 1. Resident #2 was discharged on 6/28/24. 2. DON or designee completed observation audits for enteral feedings on 7/16/24 related to residents receiving enteral feeding and HOB elevation during feeding as required. There were no concerns identified during this audit. 3. Licensed Nurses were educated by the DON or designee beginning 7/15/24 related to the requirements of elevating the HOB during enteral feeding. 4. The DON or designee will complete enteral feeding audits weekly for 12 weeks to ensure Licensed Nurses continue to be elevated residents' HOB during enteral feedings as required. The findings of these audits will be submitted to the QAPI Committee monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow-up as needed. Date of Compliance: 7/16/2024	7/16/2024

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services to maintain the highest functional status for 1 of 2 residents with gastronomy tube (GT) (Resident #2). Resident #2 had an order to have his head of bed elevated while receiving his feeding. As the nurse gave Resident #2 his feeding, they had the head of bed lowered. When Resident #2 started to vomit, the nurse stopped the feeding, but failed to elevate Resident #2's head of the bed. When the certified nurse aides attempted to assist the nurse, the nurse told them to have him lay flat. Resident #2 suffered from aspiration pneumonia and septic shock. With not having Resident #2's head of the bed raised during administration of his feeding, the facility placed Resident #2 at an immediate jeopardy due to the likelihood of serious harm and/or death. The facility identified a census of 33.

The Department notified the facility of the immediate jeopardy on 7/16/24 at 11:45 AM, that started on 6/28/24. The facility removed the immediacy on 7/16/24 by completing the following information:
a. The Director of Nursing (DON) completed observational audits on 7/16/24 related to receiving enteral (feeding via a feeding tube) and elevation of their head of bed during their feeding as required, with no concerns observed.
b. The DON educated the licensed nurses between 7/15/24 and 7/16/24. Any nurse who didn't complete the education on 7/16/24 must complete the education prior to the beginning of their next scheduled shift.
c. The DON or designed will conduct audits weekly for 12 weeks to ensure the licensed nurses continue to elevate the residents head of bed during enteral feeding as required.

The scope lowered from "J" to "D" at the time of

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the survey after ensuring the facility implemented education and their policy and procedure.

Findings include:

Resident #2's Minimum Data Set (MDS) assessment dated 5/9/24 identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Resident #2 rejected cares 1 to 3 days. Resident #2 required total assistance from staff with activities of daily living (ADL's), including repositioning. Resident #2 had functional limitation on both sides of his upper and lower extremities with range of motion (ROM). The MDS listed Resident #2 as non ambulatory. The MDS reflected Resident #2 had a catheter and a G tube (feeding tube). The MDS included diagnoses of pneumonia, pharyngeal phase dysphasia, drug induced secondary to parkinsonism, dysarthria, hypertension (htn or high blood pressure), schizophrenia, dementia, psychotic disorder, and delusions.

The Care Plan included the following Focus areas and Interventions as dated:
a. 12/27/23: Resident #2 used psychotropic medications related to (r/t) the disease process of Paranoid Schizophrenia.
b. 5/16/23: Resident #2 required a tube feeding r/t swallowing problems.
i. Revised 5/16/23: Dependent on staff with tube feedings and water flushes.
ii. 5/16/23: Monitor, document and report to the Physician as needed (PRN) for the following: Aspiration, shortness of breath (SOB), abnormal breath/lung sounds and nausea and vomiting.
iii. Revised 5/16/23: Resident #2 required the head of bed (HOB) elevated 45 degrees during

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and thirty minutes after a tube feeding.
c. 2/1/24: A nutritional problem or potential for a nutritional problem r/t dysphasia and dependence on g tube feeds with met 100% of his needs.
d. 2/5/24: An indwelling catheter.
e. 3/21/24: Resistive to cares r/t Schizophrenia.
f. 5/16/23: ADL self-care deficit.
i. 5/16/23: Required two (2) staff assistance with bed mobility. (revised 5/16/23)
ii. 5/16/23: Nothing by mouth (NPO).

Resident #2's June 2024 Medication Administration Record (MAR) included a Physician's order for enteral feeding three times a day (TID) for 30 minutes before, after, and during meals at 9 AM, 1 PM, and 7 PM.

Resident #2's Medication Admin Audit Report for 6/28/24 indicated he received his enteral feeding at 1:09 PM.

During an interview on 7/16/24 at 2:19 PM Staff D, Certified Nursing Assistant (CNA), confirmed she repositioned Resident #2 before lunch and left him at a 30-degree angle. Staff D described Resident #2 as very tired that day, they described that as normal for him around that time. Staff D confirmed Resident #2 coughed a lot and sounded like he had stuff in his lungs, so they reported her observations to Staff B, Licensed Practical Nurse (LPN).

During an interview on 7/15/24 at 2:27 PM Staff C, CNA, indicated Staff B came to her and reported Resident #2 just threw up and she needed assistance to reposition him. When the staff members entered Resident #2's room, they found him responsive but lethargic. Resident #2 requested they elevate his left arm the staff

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members repositioned him up further in the bed and elevated his arm on a pillow. Staff C confirmed Resident #2's HOB at approximately 15 degrees and that he threw up. Staff C cleaned up the emesis of tube feeding formula at which time Staff B directed her to lay Resident #2 flat. Staff C questioned Staff B why she wanted him lying flat and she replied, yes because he just threw up. Staff C only left Resident #2 flat for 1 2 minutes just long enough to pull out the chux pad out from under Resident #2. When she left Resident #2's room Staff C indicated she left Resident #2's HOB at a 30-degree angle.

During an interview on 7/15/24 at 2:43 PM Staff B stated "let me think" when asked about the event on 6/28/24. Staff B recalled Resident #2 as congested and that she typically gave him his tube feeding at 1:00 PM. On 6/28/24 she found him more lethargic than normal but they had adjusted his pain medications, so she didn't think anything about it. Staff B checked Resident #2's gastric residual with no return prior to administering his tube feeding while positioned at a 30-degree angle. Staff B indicated she denied remembering any further events and requested time overnight to gather her thoughts.

On 7/16/24 at 9:42 AM Staff B confirmed she administered Resident #2's feeding on 6/28/24 with the HOB elevated. When he had an emesis, she stopped the feeding and went to get Staff A, LPN, for a second opinion. Staff B described Staff A as a more experienced and very competent nurse, as she told him she planned to hold Resident #2's medications. Staff B reported that she couldn't recall anything else.

During an interview on 7/15/24 at 1:23 PM Staff A

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indicated on 6/28/24 around 1:50 PM or 1:55 PM, Staff B came to him and said she planned on not administering Resident #2's medications because he threw. Staff A asked Staff B if he was OK, and she indicated he was fine. So, Staff A stated he would go talk to him. At approximately 2:05 PM, Staff A entered Resident #2's room he observed Resident #2 positioned in a supine position with his head on a pillow, tube feeding formula draining from his nose, and Resident #2 non responsive. Staff A immediately raised the HOB close to a 90-degree angle. Staff A assessed Resident #2 and found an O2 (oxygen) saturation rate of 84 88%, so he increased Resident #2's oxygen to 5 liters (L) because he first thought the low oxygen saturation level caused the non responsiveness. Staff A called the Physician from Resident #2's room and received an order within approximately four (4) minutes to have transferred Resident #2 via ambulance to the local hospital. Staff A remained in the room and completed a thorough assessment. Staff B described Resident #2's blood pressure (B/P) as low, an elevated pulse (P), and a low O2 saturation. Staff B failed to complete any assessment or intervention prior to informing Staff A about the medications or Resident #2's actual condition. Staff A described Resident #2's lungs sounds as congested in the upper lobes. Staff A instructed Staff B to stay with Resident #2 while he made all of the required calls and prepared the paperwork. Resident #2 had a code status of full code (wanted life-saving measures) and they shouldn't leave him alone. As Staff A prepared Resident #2 for transfer, he observed Staff B as she entered the nurse's station. Staff A asked her what she was doing, she replied she was thirsty. Staff A directed Staff B to take her drink back down to Resident #2's room

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immediately.

During an interview on 7/15/24 at 1:49 PM the DON indicated she didn't recall the incident on 6/28/24 as Resident #2 had a lot going on and so did the facility. The DON indicated she spoke with Resident #2 prior and he didn't want to lay flat but rather requested the HOB at 45 degrees or less because of his pain.

During an interview on 7/15/24 at 4:45 PM the facilities Interim Administrator indicated the DON informed her on 6/28/24 she escorted the EMS crew to Resident #2's room and observed his HOB elevated. After explaining to the Administrator that the DON didn't report that during her interview, the DON joined the interview. She confirmed she escorted the EMS crew to Resident #2's room but never entered the room. She added she identified Resident #2's HOB as elevated because she observed Resident #2's face as she stood in the doorway of his room. The Surveyor explained a person could observe Resident #2's face from the doorway even if he laid supine, the DON shook her head with the gesture (up and down) that indicated she agreed.

An eInteract Transfer V3 form dated 6/28/24 at 2:52 PM included the following documentation but failed to address Resident #2's urinary status and catheter:
a. Blood pressure (B/P) = 84/48 (low) (average 120/80).
b. Pulse = 119 (high) (expected 80-100 beats per minute)
c. Respirations (R) = not assessed
d. Temperature (T) = 101.3 degrees Fahrenheit (F) (average temperature 98.6)

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e. Oxygen (O2) saturation = 84% (low) (expected greater than 90%).

A County Emergency Medical Services (EMS) Patient Care Report indicated the facility called the EMS crew at 2:55 PM with an arrival time of 3:00 PM. The EMS crew found the patient as he laid in bed basically unresponsive but made noises when moved. The general impression of the patient had been an elderly man with Parkinson's and severe contractures. Staff reported they went to feed Resident #2 and he vomited. Resident #2 had a feeding tube and can't eat. Resident #2 had a temperature (T) of 104 degrees Fahrenheit (F). The crew transferred the patient to the gurney and transported him to the County Regional Hospital at 3:21 PM.

During an interview on 7/15/24 at 3:57 PM one of the EMS crew members that responded to the call confirmed when they arrived on the scene, Resident #2 laid in a supine position. The EMS crew members reported finding him in bed like that, wasn't the 1st time the crew found the same resident in the supine position to transport him. The crew member verbalized concern over Resident #1's position.

The County Regional Hospital Emergency Room (ER) Progress Notes dated 6/28/24 at 3:25 PM reflected Resident #2 presented nonresponsive with a fever. Resident #2 had a history of Methicillin resistant Staph coccus Aureus (MRSA) (infection resistant to some medications) sepsis (full-body blood infection) in February 2024 from aspiration presented unresponsive from the nursing facility with a T of 104 degrees F.
According to Staff A, Licensed Practical Nurse (LPN), a nursing home nurse, the last time staff

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saw him well was around 10 AM. They brought in his G tube feeding that afternoon just prior to arrival, he vomited and became unresponsive. The patient moaned to verbal and painful stimuli.

A Radiology Results dated 6/28/24 at 3:51 PM reflected Resident #2 had nonspecific opacities (hazy gray areas in the lungs caused by a decreased ratio of gas to soft tissue in the lungs) present in the right hemithorax (right side of the chest) most prominent in the medial (middle) lung base concerning for aspiration or pneumonia. The impression identified the new opacities in the right lung, most confluent in the lung base, concerning for aspiration or pneumonia.

A County EMS Patient Care Report indicated the County Regional Hospital dispatched the crew at 5:18 PM, and they arrived on the scene at 5:30 PM. At 5:41 PM the crew transferred Resident #2 to a higher level of care hospital and arrived 6:19 PM.

The Hospital's History of Present Illness report dated 6/28/24 indicated Resident #2 presented from the emergency department (ED) of an outlying facility for septic shock. The nursing facility found him unresponsive, covered with vomit, and running high fever of 104. This prompted an immediate transfer to the local ED. The last time they reported him as well at 10 AM on 6/28/24. He moaned to verbal and painful stimuli. His blood pressure on arrival at the outlying facility ED was 60s systolic (average systolic blood pressure 120), they gave 2 liters (L) of normal saline fluid bolus, but due to his persistent hypotension (low blood pressure), they started peripheral Levophed (medication used to increase blood pressure). His chest x-ray showed

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multiple patches likely concerning for aspiration pneumonia (infection caused by breathing particulates into the lungs. The nursing home reported Resident #2 had a blocked indwelling catheter, his bladder scan showed greater than 920 milliliters (ml), the ED flushed the catheter. "Chocolate milk-like" fluid returned after the flush. The ED gave him one dose of vancomycin (antibiotic), Zosyn (antibiotic), DuoNeb (nebulizer treatment to open the lungs), started on 6 L of high flow nasal cannula, and transferred him to a larger hospital for further management. Upon arrival to the critical care unit (CCU), Resident #2 noted unresponsive with a Glasgow coma score (GCS) of 4 (indicative of severe traumatic brain injury), fever of 102, blood pressure of 68/34 systolic (average 120/80) on 30 of Levophed and started vasopressin (medication used to increase blood pressure) and emergently intubated him. The team had difficultly intubating Resident #2 due to an enlarged tongue, when the team tried to intubate, his oxygen saturation dropped to 38% (expected greater than 90%). The team removed the laryngoscope (equipment used to visualize the throat while intubating a person) and bagged him with an Ambu bag (medical equipment used to breathe for a person), his oxygen saturation improved to 90%. During that time, Resident #2 had bilious vomitus (green or yellow vomit) coming out of his mouth. The team attempted to intubate with a D blade (curved intubation equipment), successfully. The team completed a bronchoscopy to suction out the vomitus from the lungs. The team started a central access and then started on broad-spectrum antibiotics.

An Operative/Procedure Report form dated 6/28/24 at 5:27 PM indicated a Physician at the Hospital performed an Endotracheal Intubation

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for airway protection and respiratory failure.

During an interview on 7/15/24 at 3:29 PM Resident #2's Physician confirmed he expected the staff elevate Resident #2's head of his bed as far as possible but agreed to 45 degrees for Resident #2's comfort. The Physician confirmed if Resident #2 laid flat that would have caused Aspiration.

During an interview on 7/16/24 at 10:45 AM Resident #2's family member described Resident #2's current condition as gravely ill but still in the hospital. The staff at the hospital questioned brain damage due to oxygen deprivation. The family member also confirmed he observed Resident #2 positioned in a supine position during his tube feeding on two (2) separate occasions. He redirected the staff but he described them as incompetent and failed to listen.

The Enteral Feeding policy and procedure revised May 2016 included the Purpose as administration of intermittent or continuous feeding by means of a tube when the oral route or oral intake had been insufficient. The form directed the staff to assist a resident/patient to a 30 45-degree semi fowler's position and notify the Physician of any changes or concerns