STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365704	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTHCARE CENTER	**955 GARDEN LAKE PKWY TOLEDO, OH 43614**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Self-Reported Incidents (SRI) investigation, facility policy review and staff interviews, the facility failed to implement the facility policy in obtaining witness statements when investigating an incident. This affected one (#01) of three residents reviewed respiratory services. The facility census was 65. Findings include: Review of the closed medical record for Resident #01 revealed an admission date of [DATE] and re-admission date of [DATE] and date of death [DATE]. [DIAGNOSES REDACTED]. Resident #1's code status was Do Not Resuscitate- Comfort Care (DNR-CC). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was assessed as requiring oxygen therapy, suctioning, [MEDICAL CONDITION] care and utilizing a ventilator or respirator. Resident #01 was rarely or never understood and there was no cognitive assessment completed. She was assessed as requiring extensive total dependent on staff for all her Activities of Daily Living (ADLs). Review of the Self-Reported Incidents (SRI) dated 07/14/20, revealed Resident #01 passed away on 07/14/20, when she was found by State tested Nurse Aide (STNA) #100. Resident #01's ventilator was found turned off. The facility conducted interviews immediately with staff on the resident's hall. The allegation of abuse, neglect or misappropriation was not suspected and was unsubstantiated by the facility due to the evidence was inconclusive. Review of the facility investigation of SRI # 6 on 07/23/20 revealed the facility had interviewed four staff person's including STNA #100, STNA #110, Licensed Practical Nurse (LPN) #120 and Respiratory Therapist (RT) #130. The facility did not interview Housekeeper #140, who also worked on the 300-hall where the incident occurred on 07/14/20. The facility did not interview Resident #03, who was roommate to Resident #01 and was present in the room with her throughout the day of 07/14/20. The facility did not interview any of the other 19 residents who resided on the 300-hall either. The facility did not interview any other staff working in the facility on 07/14/20 at the time of the incident. Review of Resident #03's medical record revealed she was cognitively intact with a Brief Initial for Mental Status (BIMS) score of 13 out of 15. Interview with Housekeeper #140 on 07/23/20 at 2:45 P.M. she verified she was working on the 300 hall on 07/14/20 and did not didn't complete a witness statement for the investigation. Interview with Administrator on 07/23/20 at 9:11 A.M., verified there were only four staff interviewed in regards to the SRI on 07/14/20. The Administrator verified she did not interview Housekeeper #140 and verified she did not interview any other ancillary staff such as management, maintenance, dietary or activities, who could have been on the 300-hall on first shift on 07/14/20 at the time of the incident. Review of the facility policy titled Ohio Abuse, Neglect and Misappropriation revised on 04/01/19 revealed the intent of the facility to prevent the abuse, mistreatment, or neglect of residents. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow up. The executive director determines when an investigation is required and directs the investigation. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. This deficiency is an incidental finding discovered during the investigation of Complaint Number OH 323.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Self-Reported Incidents (SRI) investigation, facility policy review and staff interviews, the facility failed to complete a thorough investigation by obtaining witness statements when investigating an incident. This affected one (#01) of three residents reviewed respiratory services. The facility census was 65. Findings include: Review of the closed medical record for Resident #01 revealed an admission date of [DATE] and re-admission date of [DATE] and date of death [DATE]. [DIAGNOSES REDACTED]. Resident #1's code status was Do Not Resuscitate- Comfort Care (DNR-CC). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was assessed as requiring oxygen therapy, suctioning, [MEDICAL CONDITION] care and utilizing a ventilator or respirator. Resident #01 was rarely or never understood and there was no cognitive assessment completed. She was assessed as requiring extensive total dependent on staff for all her Activities of Daily Living (ADLs). Review of the Self-Reported Incidents (SRI) dated 07/14/20, revealed Resident #01 passed away on 07/14/20, when she was found by State tested Nurse Aide (STNA) #100. Resident #01's ventilator was found turned off. The facility conducted interviews immediately with staff on the resident's hall. The allegation of abuse, neglect or misappropriation was not suspected and was unsubstantiated by the facility due to the evidence was inconclusive. Review of the facility investigation of SRI # 6 on 07/23/20 revealed the facility had interviewed four staff person's including STNA #100, STNA #110, Licensed Practical Nurse (LPN) #120 and Respiratory Therapist (RT) #130. The facility did not interview Housekeeper #140, who also worked on the 300-hall where the incident occurred on 07/14/20. The facility did not interview Resident #03, who was roommate to Resident #01 and was present in the room with her throughout the day of 07/14/20. The facility did not interview any of the other 19 residents who resided on the 300-hall either. The facility did not interview any other staff working in the facility on 07/14/20 at the time of the incident. Review of Resident #03's medical record revealed she was cognitively intact with a Brief Initial for Mental Status (BIMS) score of 13 out of 15. Interview with Housekeeper #140 on 07/23/20 at 2:45 P.M. she verified she was working on the 300 hall on 07/14/20 and did not didn't complete a witness statement for the investigation. Interview with Administrator on 07/23/20 at 9:11 A.M., verified there were only four staff interviewed in regards to the SRI on 07/14/20. The Administrator verified she did not interview Housekeeper #140 and verified she did not interview any other ancillary staff such as management, maintenance, dietary or activities, who could have been on the 300-hall on first shift on 07/14/20 at the time of the incident. Review of the facility policy titled Ohio Abuse, Neglect and Misappropriation revised on 04/01/19 revealed the intent of the facility to prevent the abuse, mistreatment, or neglect of residents. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow up. The executive director determines when an investigation is required and directs the investigation. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. This deficiency is an incidental finding discovered during the investigation of Complaint Number OH 323.
F 0695 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of a Self-Reported Incident (SRI), review of the facility investigation and witness statements, review of a closed and open medical records, review of maintenance reports, review of alarm company reports, review of electrical sound equipment reports, review of the facility policy on mechanical ventilation overview checks and staff interviews, the facility failed to ensure necessary life-sustaining respiratory services were provided and maintained by completing daily respiratory assessments and treatments and obtaining current physician orders for the mechanical ventilator settings in accordance with facility policy for one (#01) resident. This resulted in Immediate Jeopardy and serious life-threatening harm for Resident #01 when the ventilator was found in the off position, and had gone unnoticed by

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365704	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTHCARE CENTER	955 GARDEN LAKE PKWY TOLEDO, OH 43614

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 0695 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) any of the facility staff. Consequently, Resident #01 was found unresponsive, cold, white and without respirations and had expired. This affected one (#01) of three residents reviewed for respiratory services. Additionally, two residents (#02 and #03) were placed at potential risk for harm, that did not rise to the level of Immediate Jeopardy, by failure of the facility to ensure daily respiratory assessments were provided and documented in the medical record. The facility identified nine current residents who utilize a mechanical ventilator for life-sustaining respiratory services. The facility census was 65. On [DATE] at 2:29 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at approximately 10:15 A.M., when Resident #01 was found unresponsive and cool to the touch by State tested Nurse Aide (STNA) #100 and her ventilator was turned off. STNA #100 notified Licensed Practical Nurse (LPN) #120 of Resident #01's condition and LPN #120 then went to check on Resident #01. At approximately 10:30 A.M., Resident #01 was observed to be cold and very white, had no pulse and the mechanical ventilator was found in the off position. LPN #120 with LPN #300 confirmed together Resident #01 was pulseless and without respirations at 10:35 A.M. The Immediate Jeopardy was removed on [DATE] at 6:30 A.M., when the facility implemented the following corrective actions: On [DATE] at 10:35 A.M., the facility began investigations into the ventilator being found in the off position for Resident #01. On [DATE] between 10:40 A.M. and 10:50 A.M., the DON and Director of Respiratory Therapy (DRT) #97, performed an audit of the additional residents on a mechanical ventilator. The residents were assessed for their respiratory status, ensuring physician's orders were in place and they matched the ventilator settings, and the ventilator was in the on position. On [DATE] at 11:00 A.M., Minimum Data Set (MDS) Nurse #55 began interviews with all direct care staff of Resident #01. On [DATE] at 11:15 A.M., facility Respiratory Therapists (RT) began hourly audits to monitor residents on a ventilator for ventilator settings. On [DATE] at 2:00 P.M., the emergency generators were checked for proper function by Maintenance Director (MD) #234 with no concerns. On [DATE] at 2:00 P.M. to 3:00 P.M., the local sound equipment company came in to inspect the function of the call light system and alarms. No negative findings were identified. On [DATE] beginning at 3:00 P.M., education was provided by the DON for all STNA's and nurses stating that STNA's cannot silence ventilator alarms or touch a ventilator at any time. On [DATE] at 4:00 P.M., the facility called the police and a report was made. Police came to the building and took statements. On [DATE] at 6:30 P.M., RT #130 was removed from providing direct patient care. On [DATE], the alarm company provided the alarm record for Resident #01 with no relevant findings. On [DATE], the Administrator, DON, and DRT #97 began re-education of the facility's Licensed Practical Nurses, Registered Nurses, State tested Nurse Aides, and Nursing Management on the use of a Ventilator and maintaining the ventilator in an on position, that physicians orders must be obtained for the use of the ventilator and the Respiratory Therapist must complete respiratory assessments and care of a patient on a ventilator and document daily. The education concluded on [DATE] at 6:30 A.M. On [DATE], the facility Respiratory Therapist or designee will monitor residents on a ventilator hourly. The audits will continue for eight weeks and then every shift for eight weeks and on-going thereafter. Results of the audits will be reviewed in the Quality Assurance Performance Improvement (QAPI) committee meetings for 90 days. On [DATE], DRT #97 provided education to RT #130 on the ventilator and that it will not be turned off during [MEDICAL CONDITION] care, inner cannula change or [MEDICAL CONDITION] change. On [DATE], DRT #97 provided education to all RTs on the ventilator and that it will not be turned off during [MEDICAL CONDITION] care, inner cannula change or [MEDICAL CONDITION] change. On [DATE], all facility rooms were inspected for emergency electrical components completed by MD #234 including the emergency electrical outlets, light switches, lights and call light, check enunciation light, cord and check for proper operation of the nurse call ringing back to the nurse station for the beds and restrooms for every resident room and there were no concerns identified. On [DATE] at 2:02 P.M. to 2:44 P.M., observations with DRT #97 verified all residents had their ventilators on per physician's orders. On [DATE] at 4:49 P.M., interview with RT #130 revealed he was terminated by Chief Executive Officer (CEO) #200 and the Human Resource person on [DATE] for violating policy and incorrect use of Personal Protective Equipment (PPE). RT #130 stated he was told the policy violation was related to turning off a ventilator. Although the Immediate Jeopardy was removed, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #01 revealed an admission date of [DATE], a re-admission date of [DATE] and date of death on [DATE]. [DIAGNOSES REDACTED]. Resident #01's code status was Do Not Resuscitate-Comfort Care (DNR-CC). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was assessed as requiring oxygen therapy, suctioning, [MEDICAL CONDITION] care and utilizing a ventilator or respirator. Resident #01 was rarely or never understood and there was no cognitive assessment completed. She was assessed as requiring extensive total dependence on staff for all her Activities of Daily Living (ADLs). She was incontinent of bowel and bladder and reliant on tube feeding for nutrition. Review of Resident #01's Plan of Care (POC) revealed she had a [MEDICAL CONDITION] (trach) related to impaired breathing mechanics, [DIAGNOSES REDACTED]. The goal was for Resident #01 to have clear and equal breath sounds bilaterally and no signs/symptoms of infection. Interventions included to ensure [MEDICAL CONDITION] are secured at all times, give humidified oxygen as prescribed, monitor/document for restlessness, agitation, confusion, increased or decreased heart rate, monitor/document level of consciousness, mental status, and lethargy as needed, monitor/document respiratory rate, depth and quality. Check and document every shift/as ordered and suction as necessary. Review of the physician orders revealed prior to Resident #01's hospital stay from [DATE] to [DATE], she had ventilator settings as follows: Assist Control (AC) 12/ Tidal Volume (TV) 450/ Positive End-Expiratory Pressure (PEEP) 5/ oxygen zero to four liters to maintain greater than or equal to 92% pulse oxygenation. The order was dated [DATE] and discontinued [DATE]. Review of the discharge orders from the hospital dated [DATE] revealed there was no orders for the ventilator settings. Review of the monthly physician orders for [DATE] revealed Resident #01 had no current ventilator setting orders after her return to the facility on [DATE] until her death on [DATE]. Review of the Daily Respiratory Assessments for Resident #01 from [DATE] to [DATE] revealed there were only two assessments completed for July dated [DATE] and [DATE] by a respiratory therapist. Review of Resident #01's nursing progress notes revealed on [DATE] at 10:35 A.M., the resident had no pulse, and this was verified by two nurses. Her physician was notified and gave orders to remove the ventilator. Review of the SRI dated [DATE], revealed Resident #01 passed away on [DATE], when she was found by STNA #100. Resident #01's ventilator was found turned off. The facility conducted interviews immediately with staff on the resident's hall. The allegation of abuse, neglect or misappropriation was not suspected and was unsubstantiated by the facility due to the evidence was inconclusive. Review of STNA #100's typed witness statement dated [DATE], revealed STNA #100 last observed Resident #01 around 9:00 A.M., breakfast time. STNA #100 stated Resident #01 looked like her normal self and there were no alarms going off in her room. There were no other issues noted. The statement was signed at the bottom by STNA #100. Review of STNA #110's typed witness statement dated [DATE], revealed STNA #110 last observed Resident #01 around 8:30 A.M. and stated Resident #01 looked like her normal self. There were no alarms going off in her room and no other alarms going off in the hallway or other rooms. The statement was signed at the bottom by STNA #110. Review of LPN #120's typed witness statement dated [DATE], revealed this nurse was notified by RT #130, LPN #120 and STNA #100 of vital signs ceasing at 10:35 A.M. with two witnesses confirming. STNA #100 entered the resident's room at approximately 10:35 A.M. to perform personal care. Patient was found unresponsive and ventilator off. RT #130 reported that with assessment of the ventilator, ventilator battery was fully charged and was plugged into red outlet per policy. DRT #97 notified. Administrator notified. There was no signature on the statement. This was the statement provided by the DON which the DON identified as LPN #120's statement. Review of RT #130's typed witness statement dated [DATE], revealed the ventilator was manually turned off for Resident #01. The ventilator event log showed the ventilator was turned off at 8:13 A.M. RT #130 was with another patient at that time. When RT #130 went into the room, he observed the ventilator was off. Resident #01 was observed with the inner cannula (a tube inserted through [MEDICAL CONDITION] the neck to assist with respiratory treatment) disconnected but not out of the patient. RT #130 found the ventilator off around 10:25 A.M. When RT #130 received report the morning of [DATE], Resident #01 was reported as having coffee ground emesis. The night shift had a washcloth around [MEDICAL CONDITION] absorb the emesis. There was a yellow post-it note attached at the bottom of the statement with a hand-written notation RT completed care at 7:55 A.M. There was no signature on the document by RT #130. Interview on [DATE] at 9:11 A.M. with the Administrator verified she was notified on [DATE] at 10:35 A.M., that Resident #01 was found unresponsive with no heartbeat and the ventilator was turned off. The incident investigation was started immediately. Resident #01 was last seen by LPN #120 at 10:05 A.M. and appeared her normal self. Resident #01 was found by STNA #100 at 10:35 A.M., and the ventilator was turned off. The ventilator was plugged into the red emergency outlet as required and had a full battery charge. No problems were found with the equipment, the electrical system or the alarm system. There were no alarms sounding. The Administrator denied there had been anyone in the room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365704	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTHCARE CENTER	955 GARDEN LAKE PKWY TOLEDO, OH 43614

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 0695 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) between 10:05 A.M. and 10:35 A.M. The Administrator stated to turn off the vent involved a two-step process, including manually pushing a button then verify on a screen prompt to ensure you want to power off. The facility could not determine who could have or how the ventilator was turned off. Interview on [DATE] at 11:45 A.M. with the Administrator revealed RT #130 was an employee of the hospital who was contracted to provide the respiratory service for the facility. RT #130 was suspended pending investigation by CEO #200 of the hospital because he was working on both Sunday [DATE] and Tuesday [DATE], when there were problems with the ventilators. Interview on [DATE] at 1:01 P.M. with STNA #100 verified she was Resident #01's aide on [DATE]. She was in and out of her room a couple times that morning. She stated Resident #01 was in her normal state that day and denied any problems with the ventilator, that she was aware of. STNA #100 stated she was in the room around 8:00 A.M. and RT #130 was also in the room providing care to the two residents in the room. STNA #100 did not complete Resident #01's morning care at that time. She left the room so RT #130 could do the respiratory care. STNA #100 verified she thought around 10:00 to 10:15 A.M., she found Resident #01 unresponsive. Resident #01 didn't look right and when STNA #100 touched her, she was cool to the touch. She immediately notified LPN #120. When she and the nurse returned to the room, LPN #120 checked her pulse and noted Resident #01 was gone. LPN #120 looked at the screen and observed the ventilator was off. The nurse stated Oh, my God and left to speak to the Administrator. Observation on [DATE] at 2:02 P.M. to 2:44 P.M. with DRT #97 revealed DRT #97 demonstrated how to manually turn off a ventilator. DRT #97 indicated when the ventilator was turned on, it showed a green indicator light, confirming the equipment was on and the power source was working. DRT #97 then demonstrated the two-step procedure for powering off the ventilator. DRT #97 manually pushed the on/off button which initiated a message on the information screen: power off? and the option to choose either yes or no. DRT #97 verified the yes button must be selected to complete the two-step power-off procedure and the ventilator does not alarm when turned off but emits a single beep. DRT #97 demonstrated if the ventilator had any other type of power failure, an audible alarm and the alarm display screen in the hall would both activate. Observations with DRT #97 verified all current residents on ventilators had the correct ventilator settings and were on as required. Interview on [DATE] at 3:26 P.M. with LPN #120 verified she was the nurse providing care to Resident #01 on [DATE]. LPN #120 stated she observed Resident #01 at around 10:00 A.M. when she poked her head into the room to ask the roommate if her pain medication had been effective. Resident #01 appeared to be fine at that time. She did not notice anything out of the ordinary at that time. She was not able to see Resident #01's ventilator though, as it was behind the privacy curtain and there were no alarms sounding. LPN #120 had not noted any alarms for Resident #01 at all that day. STNA #100 informed her at around 10:30 A.M., Resident #01 was unresponsive. LPN #120 went to the room with STNA #100 and found Resident #01 was cold and very white, had no pulse and the ventilator was off. LPN #120 left the room to get another nurse and LPN #300 and RT #130 both returned to the room with her. LPN #300 verified with her there were no vital signs for Resident #01. LPN #120 stated she asked RT #130 why the ventilator was off. RT #130 stated he did not know. LPN #120, LPN #300 and RT #130 all went to talk to the DON. LPN #120 added Resident #01's inner cannula was out of the [MEDICAL CONDITION], and did not think it was all the way out, but stated it was not all the way in. LPN #120 stated this would normally cause the ventilator to alarm, but, again, there were no alarms noted. LPN #120 stated during morning report, she was informed Resident #01 had a small emesis on third shift. Resident #01 did not have any emesis on first shift. Resident #01 was clean and free of emesis when LPN #120 took over care. Interview on [DATE] at 6:38 P.M. with RT #130 verified he was caring for Resident #01 on [DATE]. RT #130 stated he did [MEDICAL CONDITION], ventilator checks, cleaning of the trach, including removing and replacing the inner cannula. RT #130 stated he was in Resident #01's room completing care on [DATE] at 7:55 A.M. RT #130 denied there were any concerns with Resident #01 at the time he provided care. RT #130 stated during morning report, he was told Resident #01 had had coffee ground emesis around [MEDICAL CONDITION] on third shift. He did not recall if there was any emesis when he [MEDICAL CONDITION]. There was a washcloth around [MEDICAL CONDITION] he completed care and he removed the washcloth when he changed [MEDICAL CONDITION] and provided other care. RT #130 denied there were any audible alarms sounding but the alarm display noted to check circuit. RT #130 stated he was not able specifically to recall the specific details. However, typically he would check the circuit, checking connections and ensure everything was working correctly, then he suctions the resident regarding the check circuit alarm. RT #130 verified he completed suctioning for Resident #01. After completing care, RT #130 stated, to his recollection, the ventilator was running, and he ensured everything was working before leaving the room. At no time did RT #130 deny or confirm he turned the ventilator off. He did not see Resident #01 again prior to her death. RT #130 was busy providing respiratory care for all the residents on the 300-hall by himself that day. RT #130 stated he was preparing to see another resident when he noticed other staff at Resident #01's room. He went in to check and noticed the ventilator was off. RT #130 verified he did later receive a call from CEO #200 informing him he was suspended pending investigation. Interview on [DATE] at 11:31 A.M. with STNA #110 via phone call, verified she worked on [DATE] on the ventilator unit. She denied she provided care to Resident #01. She denied hearing any alarms for Resident #01. STNA #110 stated STNA #100 had delivered a breakfast tray to Resident #03 (Resident #01's roommate) around 8:30 A.M. The room curtain was not pulled and both residents could be seen. She stated she could see Resident #01 from the hall and RT #130 was the only person she observed go into the room. Interview on [DATE] at 4:49 P.M. with RT #130 verified he was told 8:13 A.M. was the time Resident #01's ventilator was turned off and this information had been provided by DRT #97 after he read the event log on the ventilator. RT #130 verified Resident #01 did have an inner cannula change that morning. RT #130 could not recall if he turned the ventilator off to complete the cannula change. He denied any intention to turn the ventilator off and leave it off or to cause any harm of any kind. RT #130 stated he was terminated by the hospital CEO #200 and the Human Resource Person #300 on Sunday, [DATE]. The termination was for violating the ventilator policy and incorrect use of Personal Protective Equipment (PPE). RT #130 stated he was told the policy violation was related to turning off a ventilator. RT #130 stated to his recollection, he did not turn the ventilator off while providing care to Resident #01 on [DATE]. Interview on [DATE] at 1:54 P.M. with DRT #97 verified he was RT #130's boss and they were both employed by the hospital and provided respiratory care service to the facility residents. He verified RT #130 was the RT for Resident #01 on [DATE]. DRT #97 verified RT #0130 came to him immediately on [DATE] around 10:30 to 11:00 A.M., after finding Resident #01 deceased and her ventilator turned off, to report the incident to him. RT #130 denied knowing what happened. RT #130 stated when he arrived into Resident #01's room the ventilator was turned off. They walked from the hospital side directly to Resident #01's room. Resident #01 was still in her bed, still connected to the ventilator. DRT #97 looked to see if the ventilator was plugged in and it was. DRT #97 stated he did not touch anything. Everything appeared correct. Alarm cables were connected correctly. The ventilator was off. The green indicator light was on, indicating there was no electric power problem. Under the direction of and along with Regional Director of Respiratory Therapy (RDRT) #500, DRT #97 stated he pulled the event log on Resident #01's ventilator after her death on [DATE]. When they arrived at the room, (DRT #97 was unsure of the exact time) the ventilator appeared to be appropriately connected to the red wall outlet and appeared to be in working order. They went to menu and selected the event log and scrolled through the events showing on the machine. The log showed it had powered down and to his understanding, it indicated that it had been manually shut down. The log did not indicate any mechanical failures. The date and times were noted for each event, but DRT #97 did not recall the exact date or time noted for the shut-down. After reviewing the log, they shut the machine down again. Interview on [DATE] at 3:01 P.M. with the DON and Corporate Nurse #93, both verified there were no current physician orders for the ventilator settings on [DATE] for Resident #01. Both verified the ventilator orders had expired on [DATE] and were never renewed upon Resident #01's return to the facility on [DATE]. Interview on [DATE] at 12:24 P.M. with DRT #97 revealed the only time the ventilator should be turned off was if the ventilator was discontinued or when weaning a patient off the ventilator. DRT #97 verified there would not be any reason for anyone to turn off the ventilator during routine care for a ventilator dependent resident. DRT #97 verified Resident #01 was ventilator dependent to sustain life. DRT #97 verified there was no daily assessments documented for Resident #01 by the RT. Review of Resident #01's monthly physician orders for [DATE] revealed an order dated [DATE] to change 8 disposable cannula tube (dct) one time a day; an ordered dated [DATE] [MEDICAL CONDITION] every shift and discontinued [DATE]; and an order dated [DATE] to [MEDICAL CONDITION] 8 dct Shirley every day and night shift. Review of the Medication Administration Record [REDACTED]. On [DATE] and [DATE] for the first shift, there was no documentation of the order [MEDICAL CONDITION] every shift as being completed. On [DATE] and [DATE] for the first shift, and on [DATE] for the second shift, there was no documentation of the order for change [MEDICAL CONDITION] 8 dct Shirley every day and night shift ordered as being completed. Review of the Daily Respiratory Assessments for Resident #01 from [DATE] to [DATE] revealed there were only two assessments completed for July dated [DATE] and [DATE] by a respiratory therapist. Interview on [DATE] at 3:01 P.M. with the DON verified the missing signatures on the MAR/TAR, indicating the tasks were not completed on the noted dates. 2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365704	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTHCARE CENTER	**955 GARDEN LAKE PKWY TOLEDO, OH 43614**

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 0695 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Review of the medical record for Resident #02 revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Resident #02 was ventilator dependent since admission. Review of the Daily Respiratory Assessments for Resident #02 from [DATE] to [DATE] revealed there were only three assessments completed for July dated [DATE], [DATE] and [DATE]. 3. Review of the medical record for Resident #03 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #03 used the ventilator at night and as needed in the daytime. Review of the Daily Respiratory Assessments for Resident #03 from [DATE] to [DATE] revealed there were only three assessments completed for July dated [DATE], [DATE] and [DATE]. Interview on [DATE] at 3:50 P.M. with the Administrator verified there were multiple missing Daily Respiratory Assessments for Resident #01, Resident #02 and Resident #03 from [DATE] to [DATE]. The Administrator verified the above noted assessments were the only assessments on the resident's medical records. She also verified missing MAR/TAR signatures and stated the facility has an on-going issue with it. The Administrator stated the Respiratory Therapists do a lot of documentation on paper, but it does not make it to the chart. They do not document in the computer and the facility has been dealing with the problem for a long time. Review of the facility policy titled Mechanical Ventilator Overview dated [DATE] revealed it is the policy of this facility to provide for safe, effective and resident-specific care for those residents who are either on mechanical ventilation or on the respiratory unit and are at-risk for mechanical ventilation. The respiratory care department is responsible for the set-up, management and monitoring of the ventilator. Initiate ventilator support, the physician's order must include the following: a. Mode of ventilation b. Assist Control c. Synchronized Intermittent Mandatory Ventilation (SIMV) d. Pressure Support (P. Supp) e. Pressure Control (PCV+) f. Bi Level Ventilation g. Set rate h. Tidal volume or Inspiratory Pressures i. Fraction of Inspired Oxygen (FiO2) j. PEEP or [MEDICAL CONDITION] k. Pressure Support l. Auto Flow (only) To maintain accurate and meaningful flow sheets, to ensure proper alarm function, and to assess proper ventilator function, ventilator changes will be performed by licensed respiratory therapy personnel. The therapist is to document changes on the flow sheet. Review of the facility policy titled Mechanical Ventilator Check dated [DATE] revealed it is the policy of the facility to provide resident ventilator maintenance/monitoring, as ordered by resident's physician. Resident-ventilator maintenance/monitoring is a documented evaluation of a mechanical ventilator and of the resident's response to mechanical ventilatory support. This procedure is often referred to as a ventilator check. a. Evaluate and document the resident's response to mechanical ventilation at the time that the check is performed b. Ensure the proper operation of the mechanical ventilator and document it c. Verify and document that the ventilator is functioning and is properly connected to the resident d. Verify and document that the appropriate alarms are activated e. Verify and document that inspired oxygen concentration is measured with every change in FiO2 f. Verify and document that inspired gas is properly heated and humidified g. Verify and document that ventilator settings comply with physician orders All data relevant to the resident-ventilator maintenance/monitoring must be recorded on the appropriate facility form(s) at the time of performance and be included as an official part of the resident's medical record. This deficiency substantiates Complaint Number OH 323.