STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445220	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Gate Rehab & Healthcare Center	3909 Covington Pike Memphis, TN 38135

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to follow the care plan for Activities of Daily Living (ADL) skills for 1 of 6 (Resident #3) sampled residents reviewed for ADL interventions with 2-person assistance. The findings include: 1. Review of the facility policy titled, .Comprehensive Care Planning, dated 6/30/2022, revealed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives .to meet a resident's medical, nursing, and mental and psychosocial needs that are identified . 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Diabetes, Morbid Obesity, Atrial Fibrillation, Epilepsy, Congestive Heart Failure, Chronic Kidney Disease Stage 3, Tracheostomy Status, Gastrostomy Status, and Dependence on Respirator Ventilator. Review of the Initial Care Plan Report dated 4/16/2025, revealed .Resident has an ADL self-care performance deficit .Bed Mobility .2 Person assist .Transfers .with 2 person assist AND use of mechanical lift .Resident has impaired cognitive function .Resident is at risk for/has impaired communication .Resident has impaired skin integrity .assist resident with turning and repositioning . Review of the facility's Nursing admission Evaluation, dated 4/17/2025, revealed .Activities of Daily Living . Most support needed for toileting and bed mobility .2 person assist .transfers 2 person assist with mechanical lift .Is the resident able to follow commands and cooperate .no .Is the resident cognitively impaired with poor decision-making skills .yes .at risk for falls .yes . The facility failed to follow the care plan interventions for ADL interventions related to bed mobility and repositioning with 2-person assistance when Resident #3, a severely cognitively impaired, nonmobile resident fell from the bed to the floor when Certified Nursing Assistant (CNA) B did not provide 2-person assistance with bed mobility and repositioning. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2025 at 12:58 PM, CNA B stated, .She was a total care patient .she couldn't move .I did brief checks .I did not reposition or turn her from 7 PM [7:00 PM] till about 3 AM [3 :00 AM] .I repositioned her [Resident #3] to her right side by myself . CNA B was asked if any staff assisted her to reposition Resident #3 or other residents in her section during the shift from 7:00 PM until 3:00 AM. CNA B stated, .No one helped me with any of my section .I repositioned [Resident #3] myself and got her on her side . CNA B was asked if Resident #3 was a 2-person assist to be repositioned. CNA B stated, .I really don't know .I just did it myself . During an interview on 4/30/2025 at 11:00 AM, the Director of Nursing (DON) confirmed Resident #3 required 2 person assistance with bed mobility and CNA B did not follow the care plan interventions when providing care and repositioning. The DON stated, .she [CNA B] should have asked for help .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and interview, the facility failed to ensure medications were given as ordered for 1 of 6 (Resident #3) sampled residents reviewed for medication administration. The findings include: Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Diabetes, Morbid Obesity, Atrial Fibrillation, Epilepsy, Congestive Heart Failure, Chronic Kidney Disease Stage 3, Tracheostomy Status, Gastrostomy Status, and Dependence on Respirator Ventilator. Review of the Initial Care Plan Report dated 4/16/2025, revealed .Resident has an ADL [activities of daily living] self-care performance deficit .Resident has impaired cognitive function .Administer mediations as ordered . Review of the Physician Orders dated 4/16/2025 revealed .Clonazepam [medication used to treat anxiety] .2 mg [milligrams] via [by way of] PEG [percutaneous endoscopic gastric tube] twice daily . Review of the Medication Administration Record for April 2025 revealed the facility failed to administer Clonazepam 2 mg on 4/17/2025 at 9:00 AM, and 4/18/2025 at 9:00 AM, and 9:00 PM. The facility failed to follow the physician orders for Clonazepam 2 mg to be administered twice daily for 3 doses. During an interview on 4/26/2025 at 1:00 PM, Registered Nurse (RN) D confirmed the Clonazepam was scheduled to be administered but was not in the medication cart and she failed to obtain it from the emergency drug cart, and she did not call the pharmacy to obtain the medication. RN D confirmed she did not administer the medication as ordered. During an interview on 4/30/2025 at 11:00 AM, the Director of Nursing (DON) confirmed Resident #3 did not receive the medication as ordered for 3 doses and the medication was indeed available in the emergency drug cart and should have been administered as ordered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, facility investigation review, and interview, the facility failed to provide an environment that was free from accident hazards for 1 of 3 (Resident #3) sampled residents reviewed. Resident #3, a cognitively impaired resident with a tracheostomy (a plastic tube inserted into the throat to allow the person to breath), who was a 2 person assistance for bed mobility and dependent on staff for activities of daily living skills (ADLs) including bed mobility and transfers, fell from an elevated bed and sustained a laceration to her forehead and was later pronounced deceased in the Emergency Room. The facility's failure to provide an environment that was free from accident hazards resulted in an Immediate Jeopardy (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) for Resident #3. The Administrator, Director of Nursing (DON), Regional Nurse Consultant, and [NAME] President of Operations were notified of the Immediate Jeopardy for F689 on [DATE] at 5:06 PM, in the conference room. The facility was cited at F-689 with a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy began on [DATE]. A partial extended survey was done on [DATE] through [DATE]. An acceptable Removal Plan, which removed the immediacy of the Jeopardy, was received on [DATE], and was validated onsite by the surveyor on [DATE]-[DATE]. The Immediate Jeopardy for F689 began on [DATE] through [DATE], the IJ was removed on [DATE]. The facility is required to submit a plan of correction. The findings include: 1. Review of the facility policy titled, Incident and Accident Reporting, revised [DATE], revealed .is the policy of this facility to ensure that residents are handled and transferred safely to minimize risk for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines .All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them . the resident's mobility needs will be addressed on admission and reviewed quarterly .Staff members are expected to maintain compliance with safe handling/transfer practices .Resident lifting and transferring will be performed according to the resident's individual plan of care . Review of the facility policy titled, Comprehensive Care Plans, dated [DATE], and revised [DATE], revealed . The comprehensive care plan will describe, at a minimum, the following .The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Diabetes, Morbid Obesity, Atrial Fibrillation, Epilepsy, Congestive Heart Failure, Chronic Kidney Disease Stage 3, Tracheostomy Status, Gastrostomy Status, and Dependence on Respirator Ventilator. Review of the Initial Care Plan Report dated [DATE], revealed .Resident has an ADL self-care performance deficit .Bed Mobility .2 Person assist .Transfers .with 2 person assist AND use of mechanical lift .Resident has impaired cognitive function .Resident is at risk for/has impaired communication .Resident has impaired skin integrity .assist with turning and repositioning .pressure redistribution mattress to bed . Resident #3 had an air mattress on her bed. Review of the facility's Nursing admission Evaluation, dated [DATE], revealed .Activities of Daily Living .Most support needed for toileting and bed mobility .2 person assist .transfers 2 person assist with mechanical lift . Is the resident able to follow commands and cooperate .no .Is the resident cognitively impaired with poor decision-making skills .yes .at risk for falls .yes . Review of the facility's investigation witness statement dated [DATE], revealed .Fall from bed .I [Certified Nursing Assistant (CNA) B] went into residents [resident's] room [Resident #3] approximately 310 [3:10 AM] to 320 [3:20 AM] to check resident and get her ready for repositioning .Resident [Resident #3] was lying on her side facing the window .I pulled the covers back, I undone brief and notice BM [bowel movement] coming out of it. I called for an aide to help me, so I took everything into the room and started getting it ready .At no time did I touch resident or try to reposition .The bed was at my hip level .I was standing behind resident [Resident #3] while she was in the bed, and she began to push like she was having another bowel movement and then she did a hard push and rolled off of bed face down. I couldn't grab her as she rolled. I noticed that her vent [ventilator] tubing had become lose and I yelled for the RT [Respiratory Therapist] and blood was on the floor from the resident [resident's] head .I didn't move resident off the floor and when I left the room resident [Resident #3] was still in the floor . Review of the facility's Fall During Staff Assist form revealed .[Respiratory Therapist (RT) A] .date [DATE] .I heard a call for help .as I respond to the room, the vent [mechanical ventilator] was alarming due to disconnect .patient [Resident #3] was face first on the floor .[Certified Nursing Assistant (CNA) B stated] .I was gathering my supplies to provide care .I turned her to the right .She [Resident #3] gave a large push and fell on the floor .Everything happen [happened] fast . CNA B failed to follow the care plan to use 2-person assist with bed mobility. Review of the facility's Situation, Background Assessment and Recommendation (SBAR) Communication Form and progress note dated [DATE], revealed .This nurse [RN C] notified by the CNA [CNA B] to come to room [Resident #3's room] .I noticed resident lying face down in a pool of blood .noticed open area above left brow . Review of the facility's Transfer Form dated [DATE], revealed .Usual Mental Status .Alert, disoriented, but cannot follow simple command .Current Mental Status .Not alert .Usual Functional Status .not ambulatory . Risk Alerts .Falls .ADL's .Bed Mobility, Transferring and Toileting needs assistance . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the (Named Fire Department) Record dated [DATE], revealed .Crews [Emergency Medical Services (EMS) crew] were then guided down the hall to the pts [patient's/Resident #3's] room where facility personnel were standing outside of the room as the pt [Resident #3] laid on the floor in her own feces and blood due to a fall from the bed and incontinent [loss of bowel and bladder control] .was down for 4-5 minutes prior to crews arrival .to find her breathing with a ventilator, unresponsive, blinking occasionally, and with a weak radial pulse .On arrival to the patient's [Resident #3] bedside, we [EMS crew] observed an elderly female patient [Resident #3] lying supine on the floor beside her bed. The patient [Resident #3] was unresponsive .The patient [Resident #3] had a 2-3-inch laceration to the occipital region of the scalp . remained unresponsive and had no purposeful movement .Per staff, this was consistent with her [Resident #3] baseline mental status; they reported the patient [Resident #3] is nonverbal and typically only exhibits minimal eye movement as her normal response. They further noted she had not opened her eyes since the fall, which they attributed to possible drowsiness .Neuro [neuromuscular]- Unresponsive [unable to talk or move] .Date/Time: [DATE] 03:37:00 [3:37 AM]; Head .Laceration . Review of the Hospital Emergency Department (ED) note dated [DATE] at 3:50 AM, documented by the ED physician, revealed .Physical Exam .Mottled skin pulseless, no spontaneous respirations, pupils fixed and already dilated .Time of Death 03:51 [3:51 AM] .Upon triage assessment patient is mottled and covered in feces, cold no sign of life .0552 [5:52 AM] call [Named Facility] .spoke to [Named Registered Nurse (RN) C] stated .the CNA was providing care and the patient did a hard push and ended up falling on the floor . Review of the Hospital ED Triage note dated [DATE] at 3:50 AM, documented by the ED RN, revealed .0347 [3:47 AM] [Name of the Nursing Home] called report stating patient [Resident #3] had a fall, nonverbal on trach [tracheostomy] vent, laceration to the L [left] forehead. On blood thinners. 0348 [3:48 AM]- [EMS] arrived with patient to ER [Emergency Room] .Upon triage assessment patient is mottled, patient is covered in feces, cold, no sign of life, checked for a pulse. No pulse felt .CPR [Cardiopulmonary Resuscitation] started .Unknown how long patient [Resident #3] has been without a pulse .ems states initial call came out for cardiac arrest but upon their arrival to [Name of Nursing home] reported to them [EMS] she [Resident #3] had a fall .0414 [4:14 AM] Called [Name of Nursing Home] spoke to staff member .about what happened and she [staff member] states that a staff member [CNA B] was cleaning the patient [Resident #3] when the patient rolled out of the bed falling and hitting her head .she states she [nursing home staff member] no longer wants to talk about this and would have primary nurse call us back .0505 [5:05 AM] called [name of the Nursing Home] to get more history of event states that nurse is still on break .0552 [5:52 AM] called [Name of Nursing Home] again spoke to [Name of Nursing Home Staff] the primary rn [RN] who cared for patient. [Primary Nurse stated] 'The CNA was providing care and .she [Resident #3] ended up falling on the floor .we seen [saw] her [Resident #3] on the floor and we seen [saw] the blood. We did a log roll and she [Resident #3] was still on the vent and still had vitals' . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 10:00 AM, RN C stated, .I was in another resident's room when [CNA A] yell [yelled] my name from her [Resident #3] room .I rushed to the room, I saw [Named Resident #3] lying face down on the floor beside of the bed by the window .all I could see was a lot of blood, feces and urine around her .the vent was alarming and pulse ox [oximetry (equipment placed on a finger to measure oxygen in the blood)] was alarming .the resident [Resident #3] was turned on the right side with clean linen rolled up lying on the bed against her [Resident #3] when I went in to check the pump .asked her [CNA B] what happened, she [CNA B] said she walked away, and she [Resident #3] rolled off the bed and she [Resident #3] fell on the floor . RN C was asked if she assisted CNA B with repositioning during the shift prior to the incident. RN C stated, .No .she did not ask me to help her with repositioning or to help clean her up . RN C was asked could Resident #3 roll herself from side to side or roll off the bed. RN C stated, No, she [Resident #3] would have to be turned. During an interview on [DATE] at 10:00 AM, the DON confirmed CNA B's statement was typed as CNA B was being interviewed and was not CNA B's written statement. The facility failed to provide a handwritten statement that was signed and dated by CNA B. During an interview on [DATE] at 11:00 AM, Nurse Practitioner (NP) D was asked if Resident #3 was able to turn or reposition her body or make purposeful movements to roll herself. NP D stated, .No, she [Resident #3] could not .she [Resident #3] was total dependent on staff for repositioning. NP D was asked was Resident #3 cognitively aware to answer questions or blink with her eyes appropriately to answer questions. NP D stated, .No, when I assessed her, she did not open her eyes to follow any commands .I could not get her [Resident #3] to respond or follow commands .she [Resident #3] was total dependent with her [Resident #3] care . During a telephone interview on [DATE] at 3:30 PM, RT A stated, .it was around 3:00 AM or 3:30 AM during my rounds I went to the door and saw her [Resident #3] lying on her back [in bed] the last rounding .the CNA yelled for help . I went in the room and the Resident [#3] was lying face down on the floor in blood .the ventilator was disconnected and alarming .the staff help turned her [Resident #3] over so I could connect the ventilator back. I got her [Resident #3] hooked back up and her oxygen saturations went up and she had a pulse .there was a gash on her [Resident #3] forehead and a lot of blood . During an interview on [DATE] at 11:00 AM, the DON confirmed that CNA B should have asked for assistance when providing care for Resident #3 and stated, She was a 2 person assist with bed mobility and CNA B should have asked for help to reposition and to clean her. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE]. The Removal Plan was validated onsite by the surveyor on [DATE]-[DATE] by medical record reviews, review of audits, review of [NAME]/care plans, review of staff education inservices, and interview with staff and Administration. The acceptable facility Removal Plan revealed: Identification of Residents Affected or Likely to be Affected: The facility took the following actions to review and identify residents affected or likely to be affected. (Completion Date: [DATE]) Resident #3 was discharged to the emergency room on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #3 was not appropriate for a bariatric bed. The DON, Assistant Director of Nursing (ADON), SDC (Staff Development Coordinator), IP (Infection Preventionist) nurse, Unit Managers, Nurse Supervisors, Wound Care Supervisor, or Minimum Data Set (MDS) Coordinators will review falls within the last 30 days and access resident care plans to ensure bed mobility instructions are accurate for those residents. The DON, ADON, SDC, IP nurse, Unit Managers, Nurse Supervisors, or MDS Coordinators along with a certified nursing assistant and licensed nurse who cares for the resident will review all residents for assistance with bed mobility to ensure the care plan/[NAME] reflects accurate resident requirements for the number of staff needed for bed mobility. New admissions will be reviewed for appropriate sized bed. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: [DATE]) The Administrator and Director of Nursing are reviewing the Incident/Accident Reporting policy and will take any recommendation for change to the Quality Assurance Performance Improvement (QAPI) committee. The Administrator or Director of Nursing will provide 1:1 education with the identified certified nurse assistant in regard to following care plan/[NAME] with the correct amount of assistance for turning and repositioning needs of residents. The DON, ADON, SDC, IP Nurse, Unit managers, or Nursing Supervisors will provide education to all licensed nurses and certified nursing assistants on the importance of following the care plan and [NAME] when assisting residents with bed mobility so that the correct number of staff is utilized. There will be a post-test to validate competency with required 100% accuracy. No certified nursing assistant or licensed nurse will be allowed to work after [DATE] until they have completed this training. The facility does not utilize agency staff, and any new certified nursing assistant and licensed nurse will be educated during orientation. Note: The [NAME] is instantly and automatically updated with any change to the Care Plan in the electronic medical record, so that these documents are always in sync and contain the most up to date-care plan interventions as a resource for the licensed nurses and certified nursing assistants. The DON, ADON, SDC, IP nurse, Unit Managers, Nurse Supervisors, or MDS Coordinators will observe CNAs or licensed nurses providing proper turning and repositioning and bed mobility to residents based on their care plan/[NAME] instructions. They will complete 10 observations per week for 12 weeks. An ad hoc QAPI meeting was convened on [DATE] to review the removal plan and immediate jeopardy citations with no further recommendations at this time. In attendance at a minimum were the Administrator, Director of Nursing, IP Nurse, and the Medical Director who participated by phone. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, fire department record review, and interview, the facility staff failed to document in the medical record or report the resident's tracheostomy (tube in throat to aid in breathing) was not attached when she was found unresponsive and not breathing and continuous Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) was provided for 1 of 3 (Resident #30) sampled residents reviewed for CPR. The findings include: 1. Review of the facility policy titled, Cardiopulmonary Resuscitation (CPR) & [and] Basic Life Support (BLS), revised [DATE], revealed .the purpose of this policy is to provide guidelines for the initiation of Cardiopulmonary Resuscitation (CPR)/Basic Life Support (BLS) in victims of sudden cardiac arrest .include the following procedures .Document the event in the patient's medical record . 2. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Acute Respiratory Failure, Aphasia, Dysphasia, Systemic Inflammatory Response Syndrome, Epilepsy and Aphonia, Diabetes Mellitus, and Tracheostomy. Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #30 was severely cognitive impaired with short and long-term memory problems, received continuous oxygen therapy, suctioning (procedure to remove mucus) as needed, and tracheostomy care. Review of the medical record revealed Resident #30 was found unresponsive in her room without a pulse on [DATE] at approximately 12:41 AM, by Respiratory Therapist (RT) A. Review of a Progress Note for Resident #30 dated [DATE] at 2:06 AM, by Licensed Practical Nurse (LPN) A revealed .At approximately 00:25-30 [12:25-12:30 AM], resident noted to have leg out of bed and covered up part of body .This nurse assisted resident back into position in bed and covered resident back up with blanket .Resident is in seemly [seemingly] pleasant mood upon exiting room .0 [No] s/s [signs and symptoms] of distress, pain, or discomfort . Review of the [Named Company on call Physician Note] dated [DATE] at 2:36 AM, revealed .Date of Service [DATE] at 1:33 AM . Death Notification .Summary: Death was not expected. Review of the Respiratory Therapist (RT) Progress Note for Resident #30 dated [DATE] at 3:01 AM, revealed .around 0041 [12:41 AM] while making visual round this therapist [RT A] notice [noticed] resident not breathing . There was no documentation that Resident #30's tracheostomy tube was out in the progress note documented by RT A. 3. Review of the Fire Department Prehospital Patient record revealed the fire department was called to the facility at 12:49 AM and arrived at 12:56 AM. Paramedics documented Resident #30 was found with no pulse, was not breathing, and her pupils were fixed and not reactive.the time of death was called at 1:00 AM. 4. During an interview on [DATE] at 11:25 AM, RT A stated . I was passing her door, and [she] had kicked her covers off exposing herself .I went by, and she had pulled her trach out .I put the trach back in and noticed she was non-responsive and had no pulse . RT A was asked how long the tracheostomy was out. RT A stated .I can't tell you how long the trach was pulled out .it was out, and I put it back in . RT A was asked was the tracheostomy being out or decannulated (pulled out) documented in the medical record. RT A stated, .Oh . well, it [tracheostomy] was pulled out, and I put it back in and started CPR . RT A was asked if he reported the trach being out to any staff or emergency personnel. RT A stated .No, I did not . RT A confirmed the tracheostomy being pulled was not documented in the medical record or reported to staff. During a telephone interview [DATE] at 8:00 AM, Licensed Practical Nurse (LPN B) was asked about the CPR event with Resident #30. LPN B stated, . 911 [Emergency Medical Services] had been called. LPN B was asked when you got to the room, were you told that Resident #30's tracheostomy was out. LPN B stated .No.I was never told that. During an interview on [DATE] at 11:00 AM, the Director of Nursing (DON) was asked if a tracheostomy is found dislodged or pulled out would you expect the staff to report and document that event. The DON stated, Yes, absolutely.