STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035164	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Blossom Health & Rehab Center	60 South 58th Street Mesa, AZ 85206

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 0684 Level of Harm - 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 clinical record review, staff interviews, facility documentation, and policy review, the facility failed to follow resident's advanced directives by not providing Cardiopulmonary Resuscitation (CPR) on 1 of 3 sampled residents (#21). The deficient practice could result in death of the resident. Findings include: Resident #21 was admitted on [DATE], with diagnoses of acute and chronic respiratory failure with hypoxia. Review of the Preferred Intensity of Care document signed [DATE] revealed Resident # 21's advanced directive was to receive resuscitation and transfer to an acute Hospital. A physician's order dated [DATE] included CPR Full Code, Oxygen at 3-4 liters per minute via nasal cannula, continuous, allowing to titrate up 5 liters per minute to keep oxygen saturation above 88, and pulse oximetry testing as needed for signs and symptoms of respiratory distress. According to the comprehensive care plan initiated on [DATE], the resident had oxygen therapy due to lung cancer, in which the Facility was to monitor for signs and symptoms of respiratory distress and report to the medical doctor as needed: respirations, pulse oximetry, and increased heart rate. Review of the overnight shift schedule dated [DATE] revealed the staff assigned to Resident #21 included: Certified Nursing Assistant (CNA/Staff #7) from 6:00 p.m. - 6:00 a.m., Registered Nurse (RN/Staff #4) from 6:00 p.m. - 12:00 a.m., Licensed Practical Nurse (LPN/Staff #13) from 12:00 a.m. - 6:00 a.m. RN (#55) was also scheduled to work the back cart from 6:00 p.m.- 6:00 a.m. According the Medical Administration Record (MAR) dated [DATE] at 6:15 p.m. an administration of ipratropium-albuterol solution was administered via nebulizer due to shortness of breath and wheezing. Review of vital signs dated [DATE] at 7:21 p.m., performed by CNA (#7), revealed a blood pressure of 82/48 and pulse oxygenation at 90% via nasal cannula. The MAR dated [DATE] indicated that midodrine oral tablet was administered at 9:29 pm for low blood pressure. According to the MAR, the medication was administered by RN (#4). (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	It was further documented by this RN (#4) at 9:49 p.m. the nebulizer treatment was effective. Review of the clinical record revealed no evidence of follow up of the effectiveness of the midodrine on the critically low blood pressure nor documentation of physician being contacted. A Nursing progress note dated [DATE] at 3:03 a.m., written by LPN (#13) revealed that Resident (# 21) was found by a CNA (not identified) at approximately 2:00 a.m. cold and unresponsive. According to the progress note, CPR was initiated. Review of the record revealed no evidence on who initiated CPR and what time CPR was initiated. The Director of Nursing (DON/ Staff #6) was notified at 2:30 a.m. by LPN (#13). LPN (#13) was given instruction to call 911, at that time. Emergency Medical Technicians (EMTs) arrived at approximately 2:35 a.m. and resident was pronounced deceased at 2:40 a.m. An EMT report dated [DATE], revealed that EMTs were called at 2:34 a.m. and were on the scene at 2:37 a.m. When they arrived to the Facility, CPR was not being conducted, instead Resident (#21) had her sheets pulled over her entire body and staff said that Resident (#21) was deceased . When staff was asked when Resident (#21) was last seen normal, the staff stated they did not know. On assessment performed by the EMTs, Resident (#21) was apneic, pulseless, and unresponsive. Resident (#21) was cold to the touch, stiff, with dependent lividity present. No signs of trauma were present. LPN (#13) signed Transfer of Patient Care for Resident (#21) and stated they would contact family. A phone interview was attempted with LPN (#13) on [DATE] at 3:10 p.m. and on [DATE] at 9:28 a.m. No contact was made. An interview with a CNA (#7) was conducted on [DATE] at 3:14 p.m., CNA (#7) stated that she was assigned to Resident's (#21) room on the overnight shift on [DATE]. She stated that Resident (#21) was wheezing and not feeling well. She further stated that Resident's (#21) roommate, Resident (#36), had pressed her call light concerned for resident, telling staff that Resident (#21) was asking to go to hospital. CNA (#7) informed RN (#4) about Resident (#21) condition and her wanting to go to the hospital. RN (#4) informed CNA (#7) that Resident's (#21) physician was aware. Review of the clinical record reveled no evidence that Nurse (#4) assessed the resident at this time. According to CNA (#7) she went into Resident's (#21) room at approximately 1:40 a.m., and the resident was struggling to breath so she put her nasal cannula on. Review of the clinical record revealed no evidence that the provider was notified during this time. She returned around 2:00 a.m. to check on resident and discovered she was not breathing. She stated that she was unaware of the resident's code status so she called LPN (#13) and asked her. CNA reported that LPN (#13) came into the room assessed the resident and told her that CPR was not necessary because Resident (#21) had clearly passed. CNA (#7) stated that LPN (#13) and RN (#55) discussed what to do and decided to call DON (#6) and EMS. CNA (#7) stated that during this time a Code was never called and CPR was not performed. An interview with RN (#4) was conducted on [DATE] at 3:29 p.m. RN (#4) reported not remembering Resident (#21). She could not recall any incident with Resident (#21). Attempted phone interview with RN (#55) on [DATE] at 3:27 p.m. and then again on [DATE] at 9:25 a.m. A voicemail message was left both times with no return calls. Facility tried to reach out to RN (#55) and reported they were unable to get ahold of her but confirmed she was still employed with facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview with CNA (#43) was conducted on [DATE] at 8:56 a.m. She stated the Facility's process during a code would be to call for help and start getting everything ready, once help arrives, compressions are started and someone else will do the bag. Whoever is not doing compressions usually makes the phone call to EMS. We do this until EMS arrives and takes over. EMS does not take long because they are right next door to us. CNA replied the nurses can get CPR status in the electronic medical record (EMR), a CNA would not have access to that so they would have to look in the books at the nurses' station. CNA (#43) stated that LPN (#13) was let go and had not seen her in the last two weeks. An interview with LPN (#29) was conducted on [DATE] at 9:10 a.m. who stated that the procedure for a code included checking the code status on the computer then check vitals and start CPR, LPN (#29) stated that she would assign someone to call 911. If a CNA discovered a resident, they would call the code through the walkies and check with nurses on code status or look at nurses' station for the paper copies. We train codes here at the facility we just had a mock code a couple weeks ago. She stated that once CPR has been initiated, it isn't stopped until EMS takes over. LPN (#29) stated that EMS will pronounce the patient, the only time nurses can pronounce is if they have a Do Not Resuscitate (DNR) order or are on Hospice. Attempted phone interview with Resident (#36), the roommate to Resident (#21) at the time of the incident, on [DATE] at 10:00 a.m. Phone number was not in operation. An interview with Human Resources Director (HR/Staff #16) on [DATE] at 11:16 a.m. stated that LPN (#13) was terminated on [DATE]. She stated that when a staff member is terminated the manager fills out a termination form and HR (#16) enters into the computer. Usually, corrective actions are conducted by the manager and administrator. She stated that she does not sit in on corrective actions. She reported that there was an investigation conducted by DON (#6) regarding LPN (#13). She recalled that the investigation was about a death and not following procedures but she did not have details. When HR (#16) reviewed her computer, she stated the official reason for LPN's (#13) termination was misconduct. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview with DON (#6) on [DATE] at 12:05 p.m. stated that during a code, if a resident is found pulseless and not breathing staff will check status, call 911 and call a code blue on the walkies or over the speaker. She stated that staff know the code status because it is in the resident's orders in the Electronic Medical Record (EMR), or there is a binder for the CNAs at the nurses' desk. DON (#6) stated CNAs typically ask the floor nurse as they have immediate access to the chart. CPR is initiated by whomever discovers resident as long as they are certified to perform CPR. She stated that 911 is usually called immediately and they are next door. The faster they get here the sooner we can stop doing CPR because they will take over. DON (#6) responded that EMS or provider would pronounce death if in building. The only time nurses can pronounce death is if the resident status is a DNR or the resident is a Hospice patient, then two nurses can pronounce death. The DON then reviewed Resident's (#21) chart regarding her code. DON stated that Resident (#21) was a full code. DON identified resident change of condition and pointed out last blood pressure was low taken at 7:21 p.m., and facility provided fluids and midodrine. DON reviewed chart for documentation on midodrine follow up. She said staff typically write in MAR the effectiveness but was unable to locate another note in the chart. She went on to state that Resident (#21) was found unresponsive about 2:00 a.m. per the progress note, and CPR started. The DON also stated that she was contacted about 30 minutes later by LPN (#13) about the incident. DON instructed LPN (#13) to call EMS. DON said that there was some confusion by LPN (#13), who thought she could pronounce death with another nurse. DON had to inform LPN (#13) not on a full code resident and EMS needed to be dispatched immediately. DON reiterated that during the 30 minutes from when Resident (#21) was identified until EMS arrived, CPR never stopped, and was performed by CNA #7. DON stated that EMS arrived around 2:35 p.m., and took over. EMS pronounced her dead at 2:40 a.m. The DON said later there was a debrief of the code and CNA (#7) told me she started CPR and we discussed who gets contacted and when. Per DON a mock code for staff was conducted a couple weeks later. DON stated that LPN (#13) was investigated for being disrespectful to coworkers and pushing back on her duties that she felt were not part of her job. DON (#6) stated she believed the staff followed protocol during this incident. Review of Change of Condition Reporting Policy dated [DATE], included for life threatening changes a licensed nurse will initiate appropriate first aid measures until emergency response personnel arrive on scene. Licensed nurse will inform primary physician (alternate physician, or Medical Director) of resident status as soon as possible once resident needs have been met and immediacy of nursing care is completed. It goes on to include, all nursing actions, physician contacts, resident representative, and resident assessment information will be documented in the nursing progress note. Review of CPR and First Aid policy dated [DATE], once CPR is initiated, it will be discontinued only by a physician's order and or the arrival of rescue personnel who take over CPR efforts and/or transport the resident.