STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055003	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eureka Rehabilitation & Wellness Center, LP	2353 Twenty Third St Eureka, CA 95501

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one licensed nurse (Licensed Nurse 1 (LN 1)) of two licensed nurses maintained an appropriate Cardiopulmonary Resuscitation (CPR) certification when LN 1 did not obtain CPR certification through a provider with hands on training.This failure decreased the facility's potential to be able to implement of life saving measures and effective clinical interventions for all residents residing in the facility in the event of a respiratory or cardiac emergency.A review of LN 1's employee file indicated LN 1 was hired as a registry (agency that employs nursing staff for facilities with urgent staffing needs) nurse. Further review of LN 1's file indicated LN 1 obtained CPR certification through an online provider on [DATE].A review of the online provider's website indicated candidates were trained to the AHA [American Heart Association] (R)?2020 cognitive guidelines where course modules may be purchased and accessed 24 hours per day, 365 days per year. The test may be taken at any time, in an unlimited amount. There was no validation of skills technique indicated with this online provider. The site offers instant certification based solely on a written exam, which bypasses the critical hands-on component.During an interview on [DATE] at 8:01 a.m., the Administrator (ADM) stated all licensed nurses needed to maintain CPR certification with hands-on training and further stated, This means performing the skills on a mannequin. This also applied to registry nurses. The ADM stated hands-on assessment during CPR certification was important as it validated the proper techniques that were being used.A review of facility policy titled Cardiopulmonary Resuscitation, dated 2022, indicated, The facility shall ensure properly trained personnel (and certified in CPR for Healthcare Providers are available immediately to provide basic life support, including cardiopulmonary resuscitation (CPR).The facilities procedure for administering CPR shall incorporate the guidance from the American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.Licensed Nursing staff shall maintain current CPR for Healthcare Providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor led setting, in accordance with accepted national standards.

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 - 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 interview and record review, the facility failed to ensure a professional standard of nursing care was provided to one resident (Resident 1) of two sampled residents when:- Licensed Nurse 1 (LN 1) did not document an assessment and Change of Condition (COC) of Resident 1 after Certified Nurse Assistant 1 (CNA 1) notified her that Resident 1 had a change in his breathing on [DATE] at approximately 3 p.m.;- LN 1 administered a medicated breathing treatment to Resident 1 without a physician's order and documented she administered the breathing treatment on the wrong day; and,- LN 1 called for a non-emergent ambulance when Resident 1 was found unresponsive with labored breathing and a faint pulse. These failures decreased the facility's potential to ensure care provided to Resident 1 met professional standards of quality nursing care and may have contributed to a delay in Resident 1 being transferred to a higher level of care sooner.Findings:A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] with a diagnoses which included Chronic Obstructive Pulmonary Disease (COPD, a progressive, irreversible lung disease that restricts airflow, making it hard to breathe) and asthma (a chronic, respiratory condition caused by swelling and mucus production that narrows the airways of the lungs resulting in wheezing, chest tightness, and shortness of breath).A review of Resident 1's care plan related to his diagnosis of COPD and asthma, initiated [DATE], indicated licensed nurses were expected to implement the following interventions when Resident 1 had a concern regarding difficulty breathing, Give aerosol or bronchodilators as ordered. Monitor/document side effects and effectiveness. Monitor for s/sx [signs and symptoms] of acute respiratory insufficiency: Anxiety [persistent fear or worry], Confusion, Restlessness, SOB [shortness of breath] at rest, Cyanosis [blue skin], Somnolence [excessive drowsiness].Monitor/document/report PRN [as needed] any s/sx of respiratory infection: Fever, Chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing.A review of the facility's document titled Contract Services Orientation Information signed on [DATE] by LN 1 indicated, Change in Resident Condition: It is of the utmost importance that our clinical staff are able to detect and report changes in a resident's physical.condition in a timely manner.The assigned [licensed] nurse shall complete the S-BAR [Situation-Background, Assessment, and Recommendation] and notify the licensed independent practitioner immediately upon identification of a change in condition.A review of Resident 1's order listing report indicated Resident 1 had the following physician's orders:-Starting on [DATE], staff was supposed to provide Resident 1 with Cardiopulmonary Resuscitation (CPR) in the event Resident 1's heart stopped beating or Resident 1 stopped breathing; and,- Starting on [DATE], staff was supposed to add a progress note during every shift regarding Resident 1's lung sounds.The order listing report further indicated both of these orders were discontinued on [DATE] at 3: 26 p.m.A review of Resident 1's progress notes dated [DATE] indicated no documented evidence of: an assessment, a COC related to Resident 1's respiratory status between 3 p.m. and 6:30 p.m., notification of Resident 1's COC to the physician, treatment provided, and monitoring of effectiveness of the treatment.A review of Resident 1's progress note dated [DATE] at 7:43 p.m., LN 1 documented, Approx: [6:40 p.m.] [LN 1] was notified by [CNA 1] that.[Resident 1] was breathing rapidly. [LN 1] went in to see [Resident 1] O2 sats [saturation, the percentage of oxygen in a person's blood] were 93% .[LN 1] asked [Resident 1] if resident wanted to go to hospital [Resident 1] said no.Approx [7:05 p.m.] [CNA 1] came and said O2 levels dropped to 63%. Both [LN 1] and [LN 2] went to assess [Resident 1] and decided to send resident out [to hospital]. Approx [7:05 p.m.] [LN 1] called non emergent [ambulance].A review of Resident 1's progress note dated [DATE] at 7:50 p.m., LN 2 (continued on next page)

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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	documented, [LN 2] arrived on shift at [6:53 p.m.].[CNA 1] came to nurses [sic] station approximately [7 p.m.] reporting that [Resident 1] reports SOB [shortness of breath], and has O2 level of 63% RA [room air].O2 SAT on the monitor was recorded at 72% RA, [LN 2] instructed [LN 1] to call 911 [EMS]. [Resident 1] was unresponsive with labored, rapid breathing, resident had a very faint pulse.[Resident 1's] breaths became shorter and shorter in between and pulse was fading.Tx [treatment] nurse had began chest compressions.[LN 2] took over compression for Tx nurse while oxygen was placed on the resident via mask.EMS arrived and placed.pads on resident, called to clear, and took over CPR.A review of Resident 1's emergency room (ER) provider note dated [DATE] at 8:13 p.m. indicated, .Per EMS report, [Resident 1] was found down and apneic [not breathing] by [facility] staff 30 minutes prior to arrival [in ER].Reportedly, [Resident 1's] last known normal was [6:30 p.m.] today .albuterol 2.5 mg [milligrams, a unit of measurement]/ 3 mL [milliliters, a unit of measurement] nebulizer solution [medication used to treat COPD and asthma].Take 3 mL by nebulization [the use of a medical device that converts a liquid medication into a fine mist allowing residents to inhale the medication into their lungs] every 4 hours as needed for shortness of breath. ([Resident 1] not taking: Reported on [DATE].).A review on Resident 1's progress note dated [DATE] at 3:34 p.m. indicated that LN 1 documented, Late entry. At approx. [6:45 p.m.] on [DATE] [sic] writer administered breathing treatment [medication used to treat COPD and asthma]. While writer was on phone the resident started to code [cardiac or respiratory arrest] and the non-emergent transferred call to 911. There was no documented evidence what medication LN 1 gave to Resident 1 as a breathing treatment or that it was administered on [DATE].A review of Resident 1's physician's order dated [DATE] at 3:57 p.m. indicated the following order was placed for Resident 1, Created [DATE] [at 3:27 p.m.].Albuterol Sulfate Nebulization Solution (2.5 MG/3ML).1 vial inhale orally via nebulizer one time only for SOB until [DATE] [7 p.m.].Discontinue [DATE] [at 3:26 p.m.].Discontinue.Reason: Resident expired at ED [Emergency Department].During an interview on [DATE] at 1:41 p.m., CNA 1 stated she had worked with Resident 1 since he was admitted to the facility. CNA 1 stated when she started her shift on [DATE] at 3 p.m., she noticed Resident 1 appeared to have some difficulty breathing. CNA 1 stated, He sounded like he had a lot of mucus in his lungs, it was noisy breathing. CNA 1 stated Resident 1 reported shortness of breath and when CNA 1 checked Resident 1's O2 saturation (the amount of oxygen in the blood), she found it fluctuated between 85-95% on room air. CNA 1 escalated this concern to LN 1 but LN 1 responded Resident 1 was fine. CNA 1 further stated, As time passed, the sound of his breathing got worse. I told LN 1 three or four more times that Resident 1 was getting worse, but she [LN 1] kept telling me he [Resident 1] was fine. CNA 1 stated when Resident 1's O2 saturation read 35%, she asked CNA 2 to assist her in getting LN 1 to physically go into Resident 1's room and assess him. CNA 1 stated LN 1 finally assessed Resident 1 and administered a breathing treatment for him nearly four hours after she initially notified her of Resident 1's difficulty breathing. CNA 1stated, I told him [Resident 1] I was trying to help him. He looked so scared.During an interview on [DATE] at 9:01 a.m., the surveyor attempted to interview LN 1, but LN 1 stated, Unless I have the [Electronic Medical Record (EMR)] in front of me, I cannot answer your question. I no longer work at that facility and unless they want to pay me to go in there and look up my notes, I cannot help you. LN 1 then hung up the phone on the Surveyor.During an interview on [DATE] at 3:32 p.m., CNA 2 stated CNA 1 had been worried about Resident 1 at the beginning of the shift on [DATE]. CNA 2 stated CNA 1 had told her Resident 1 was acting differently and was making an awful sound while breathing. CNA 2 stated at one point she entered Resident 1's room with CNA 1 and Resident 1 was gurgling. CNA 2 stated CNA 1 measured Resident 1's vital signs and his O2 saturation was really low and further stated it was the lowest O2 saturation (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had ever seen. CNA 1 then asked CNA 2 to notify LN 1 of Resident 1's condition because LN 1 had not been listening to CNA 1's concerns. CNA 2 stated she did alert LN 1 but was not sure what happened after that.A review of Resident 1's Medication Administration Record dated [DATE] and printed on [DATE] at 1:54 p.m. indicated no documented evidence that albuterol sulfate nebulization solution was administered to Resident 1 on any day in [DATE].During an interview on [DATE] at 8:01 a.m., the Administrator (ADM) stated licensed nurses were expected to assess residents when a CNA reported a resident abnormality or concern regarding resident safety or health. The nurse was also expected to document the assessment in the EMR, and to keep an eye on the resident during the remainder of the shift. The ADM further stated nursing staff were expected to call 911 (EMS) for residents who were not breathing or had no pulse.During an interview on [DATE] at 4:20 p.m., Resident 1's physician (MD) stated she had concerns with the nurse caring for him that shift. The MD stated on [DATE], LN 1 had not provided any notification to the physician of Resident 1's complaints or symptoms of shortness of breath. The MD confirmed she had not received a call from LN 1 to request a respiratory treatment order for Resident 1 that day. The MD further stated she was unsure if nurses could initiate treatment without physician orders but added a respiratory treatment would be ineffective for a resident who was coding (experiencing a cardiac or respiratory arrest). The MD stated she had only received one call from LN 1 that day and it was to notify her that Resident 1 had already coded and had been sent to the hospital.A review of an e-mail from the facility's medical records department dated [DATE] at 12 p.m. indicated there were no other notes documented by LN 1 on [DATE] and confirmed the only documented COC was time-stamped at 7:43 p.m.During an interview on [DATE] at 9:23 a.m., CNA 1 stated Resident 1 stated he was so tired on [DATE] and was not feeling well. CNA 1 stated she had not heard LN 1 ask Resident 1 if he wanted to go to the hospital.During an interview on [DATE] at 9:33 a.m., the Director of Nursing (DON) stated nurses were expected to always document a COC and include what occurred, what they did about it, who they contacted, and the resident's response. The DON further stated Resident 1 had medicated breathing treatment in the medication cart but did not have an active order for them to be administered. The previous order for the medicated breathing treatment expired on [DATE].During an interview on [DATE] at 1:42 p.m., the DON stated if a resident had an O2 saturation of 63% she expected the LN to assess the resident, apply oxygen, notify the MD, get an order for a breathing treatment, and update the MD on the resident's condition. The nurse would be expected to document all of this in the EMR and carry out any additional orders the MD gave.During an interview on [DATE] at 5:12 p.m., LN 2 confirmed she had instructed LN 1 to call 911 and not a non-emergent ambulance for Resident 1. LN 2 stated LN 1 told her she had called for a non-emergency ambulance and LN 2 asked her why she would do that in an emergency, but LN 1 did not respond. LN 2 acknowledged LN 1 had informed her she gave Resident 1 a breathing treatment, but LN 1 saw that there was no active order and when she asked if it was effective LN 1 was unable to answer. LN 2 stated that two CNAs had already reported to her that Resident 1 did not look right and when they had notified LN 1 about it, she did not act. So, when LN 1 told LN 2 she had asked Resident 1 if he wanted to go to the hospital and he replied no, she did not trust what LN 1 had stated.A review of the facility's policy and procedure (P&P) titled Change in Condition dated 2022 indicated, The licensed nurse will assess the change of condition and determine what nursing interventions are appropriate. Before notifying the physician.the licensed nurse must observe and assess the overall condition utilizing a physical assessment and chart review.the licensed nurse will notify the physician when there is.A significant change in the resident's physical.status e.g., deterioration of health.or clinical complications.the licensed nurse will document.Date, time and pertinent details of the event and subsequent (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment in the medical record.The time the Physician.was contacted.and whether or not orders were received.A review of the facility's P&P titled Cardiopulmonary Resuscitation reviewed [DATE] indicated, Responding to Cardiopulmonary Emergency.Check the victim for responsiveness, respirations, and pulse.call 911.A review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised [DATE] indicated, The Facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety.needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.A review of the facility's P&P titled Medication-Administration revised [DATE] indicated, All medication shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations.The time and dose of the medication or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the medication or treatment.

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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 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 interview and record review, Licensed Nurse 1 (LN 1) failed to ensure one (Resident 1) of two residents' medical records were complete and accurate when:-LN 1 did not document an assessment and Change of Condition (COC) of Resident 1 after Certified Nurse Assistant 1 (CNA 1) notified her that Resident 1 had a change in his breathing on [DATE] at approximately 3 p.m.; and,- LN 1 administered a medicated breathing treatment to Resident 1 without a physician's order and documented she administered the breathing treatment on the wrong day.These failures decreased the facility's potential to facilitate communication among healthcare staff and decreased the facility's potential to investigate and determine if there was a correlation between facility staff's response to Resident 1's COC and Resident 1's need for cardiopulmonary resuscitation (CPR).Findings:A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] with a diagnoses which included Chronic Obstructive Pulmonary Disease (COPD, a progressive, irreversible lung disease that restricts airflow, making it hard to breathe) and asthma (a chronic, respiratory condition caused by swelling and mucus production that narrows the airways of the lungs resulting in wheezing, chest tightness, and shortness of breath).A review of Resident 1's care plan related to his diagnosis of COPD and asthma, initiated [DATE], indicated licensed nurses were expected to implement the following interventions when Resident 1 had a concern regarding difficulty breathing, Give aerosol or bronchodilators as ordered. Monitor/document side effects and effectiveness. Monitor for s/sx [signs and symptoms] of acute respiratory insufficiency: Anxiety [persistent fear or worry], Confusion, Restlessness, SOB [shortness of breath] at rest, Cyanosis [blue skin], Somnolence [excessive drowsiness].Monitor/document/report PRN [as needed] any s/sx of respiratory infection: Fever, Chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing.A review of the facility's document titled Contract Services Orientation Information signed on [DATE] by LN 1 indicated, Change in Resident Condition: It is of the utmost importance that our clinical staff are able to detect and report changes in a resident's physical.condition in a timely manner.The assigned [licensed] nurse shall complete the S-BAR [Situation- Background, Assessment, and Recommendation] and notify the licensed independent practitioner immediately upon identification of a change in condition.A review of Resident 1's order listing report indicated that starting on [DATE], staff were supposed to add a progress note during every shift regarding Resident 1's lung sounds. The order listing report further indicated that this order was discontinued on [DATE] at 3: 26 p.m.A review of Resident 1's progress notes dated [DATE] indicated no documented evidence of: an assessment, a COC related to Resident 1's respiratory status between 3 p.m. and 6:30 p.m., notification of Resident 1's COC to the physician, treatment provided, and monitoring of effectiveness of the treatment.A review of Resident 1's progress note dated [DATE] at 7:43 p.m., LN 1 documented, Approx: [6:40 p.m.] [LN 1] was notified by [CNA 1] that.[Resident 1] was breathing rapidly. [LN 1] went in to see [Resident 1] O2 sats [saturation, the percentage of oxygen in a person's blood] were 93% .[LN 1] asked [Resident 1] if resident wanted to go to hospital [Resident 1] said no.Approx [7:05 p.m.] [CNA 1] came and said O2 levels dropped to 63%. Both [LN 1] and [LN 2] went to assess [Resident 1] and decided to send resident out [to hospital]. Approx [7:05 p.m.] [LN 1] called non emergent [ambulance].A review of Resident 1's progress note dated [DATE] at 7:50 p.m., LN 2 documented, [LN 2] arrived on shift at [6:53 p.m.].[CNA 1] came to nurses [sic] station approximately [7 p.m.] reporting that [Resident 1] reports SOB [shortness of breath], and has O2 level of 63% RA [room air].O2 SAT on the monitor was recorded at 72% RA, [LN 2] (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructed [LN 1] to call 911 [EMS]. [Resident 1] was unresponsive with labored, rapid breathing, resident had a very faint pulse.[Resident 1's] breaths became shorter and shorter in between and pulse was fading.Tx [treatment] nurse had began chest compressions.[LN 2] took over compression for Tx nurse while oxygen was placed on the resident via mask.EMS arrived and placed.pads on resident, called to clear, and took over CPR.A review of Resident 1's emergency room (ER) provider note dated [DATE] at 8:13 p.m. indicated, .Per EMS report, [Resident 1] was found down and apneic [not breathing] by [facility] staff 30 minutes prior to arrival [in ER].Reportedly, [Resident 1's] last known normal was [6:30 p.m.] today .albuterol 2.5 mg [milligrams, a unit of measurement]/ 3 mL [milliliters, a unit of measurement] nebulizer solution [medication used to treat COPD and asthma].Take 3 mL by nebulization [the use of a medical device that converts a liquid medication into a fine mist allowing residents to inhale the medication into their lungs] every 4 hours as needed for shortness of breath. ([Resident 1] not taking: Reported on [DATE].).A review on Resident 1's progress note dated [DATE] at 3:34 p.m. indicated that LN 1 documented, Late entry. At approx. [6:45 p.m.] on [DATE] [sic] writer administered breathing treatment [medication used to treat COPD and asthma]. While writer was on phone the resident started to code [cardiac or respiratory arrest] and the non-emergent transferred call to 911. There was no documented evidence what medication LN 1 gave to Resident 1 as a breathing treatment or that it was administered on [DATE].A review of Resident 1's physician's order dated [DATE] at 3:57 p.m. indicated the following order was placed for Resident 1, Created [DATE] [at 3:27 p.m.].Albuterol Sulfate Nebulization Solution (2.5 MG/3ML).1 vial inhale orally via nebulizer one time only for SOB until [DATE] [7 p.m.].Discontinue [DATE] [at 3:26 p.m.].Discontinue.Reason: Resident expired at ED [Emergency Department].During an interview on [DATE] at 1:41 p.m., CNA 1 stated she had worked with Resident 1 since he was admitted to the facility. CNA 1 stated when she started her shift on [DATE] at 3 p.m., she noticed Resident 1 appeared to have some difficulty breathing. CNA 1 stated, He sounded like he had a lot of mucus in his lungs, it was noisy breathing. CNA 1 stated Resident 1 reported shortness of breath and when CNA 1 checked Resident 1's O2 saturation (the amount of oxygen in the blood), she found it fluctuated between 85-95% on room air. CNA 1 escalated this concern to LN 1 but LN 1 responded Resident 1 was fine. CNA 1 further stated, As time passed, the sound of his breathing got worse. I told LN 1 three or four more times that Resident 1 was getting worse, but she [LN 1] kept telling me he [Resident 1] was fine. CNA 1 stated when Resident 1's O2 saturation read 35%, she asked CNA 2 to assist her in getting LN 1 to physically go into Resident 1's room and assess him. CNA 1 stated LN 1 finally assessed Resident 1 and administered a breathing treatment for him nearly four hours after she initially notified her of Resident 1's difficulty breathing. CNA 1stated, I told him [Resident 1] I was trying to help him. He looked so scared.During an interview on [DATE] at 9:01 a.m., the surveyor attempted to interview LN 1, but LN 1 stated, Unless I have the [Electronic Medical Record (EMR)] in front of me, I cannot answer your question. I no longer work at that facility and unless they want to pay me to go in there and look up my notes, I cannot help you. LN 1 then hung up the phone on the Surveyor.During an interview on [DATE] at 3:32 p.m., CNA 2 stated CNA 1 had been worried about Resident 1 at the beginning of the shift on [DATE]. CNA 2 stated CNA 1 had told her Resident 1 was acting differently and was making an awful sound while breathing. CNA 2 stated at one point she entered Resident 1's room with CNA 1 and Resident 1 was gurgling. CNA 2 stated CNA 1 measured Resident 1's vital signs and his O2 saturation was really low and further stated it was the lowest O2 saturation she had ever seen. CNA 1 then asked CNA 2 to notify LN 1 of Resident 1's condition because LN 1 had not been listening to CNA 1's concerns. CNA 2 stated she did alert LN 1 but was not sure what happened after that.A review of Resident 1's Medication Administration (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	Record dated [DATE] and printed on [DATE] at 1:54 p.m. indicated no documented evidence that albuterol sulfate nebulization solution was administered to Resident 1 on any day in [DATE].During an interview on [DATE] at 8:01 a.m., the Administrator (ADM) stated licensed nurses were expected to assess residents when a CNA reported a resident abnormality or concern regarding resident safety or health. The nurse was also expected to document the assessment in the EMR, and to keep an eye on the resident during the remainder of the shift.During an interview on [DATE] at 4:20 p.m., Resident 1's physician (MD) stated she had concerns with the nurse caring for him that shift. The MD stated on [DATE], LN 1 had not provided any notification to the physician of Resident 1's complaints or symptoms of shortness of breath. The MD confirmed she had not received a call from LN 1 to request a respiratory treatment order for Resident 1 that day. The MD further stated she was unsure if nurses could initiate treatment without physician orders but added a respiratory treatment would be ineffective for a resident who was coding (experiencing a cardiac or respiratory arrest). The MD stated she had only received one call from LN 1 that day and it was to notify her that Resident 1 had already coded and had been sent to the hospital.A review of an e-mail from the facility's medical records department dated [DATE] at 12 p.m. indicated there were no other notes documented by LN 1 on [DATE] and confirmed the only documented COC was time-stamped at 7:43 p.m.During an interview on [DATE] at 9:23 a.m., CNA 1 stated Resident 1 stated he was so tired on [DATE] and was not feeling well. CNA 1 stated she had not heard LN 1 ask Resident 1 if he wanted to go to the hospital.During an interview on [DATE] at 9:33 a.m., the Director of Nursing (DON) stated nurses were expected to always document a COC and include what occurred, what they did about it, who they contacted, and the resident's response.During an interview on [DATE] at 1:42 p.m., the DON stated if a resident had an O2 saturation of 63% she expected the LN to assess the resident, apply oxygen, notify the MD, get an order for a breathing treatment, and update the MD on the resident's condition. The nurse would be expected to document all of this in the EMR and carry out any additional orders the MD gave.A review of the facility's policy and procedure (P&P) titled Change in Condition dated 2022 indicated, The licensed nurse will assess the change of condition and determine what nursing interventions are appropriate. Before notifying the physician.the licensed nurse must observe and assess the overall condition utilizing a physical assessment and chart review.the licensed nurse will notify the physician when there is.A significant change in the resident's physical.status e.g., deterioration of health.or clinical complications.the licensed nurse will document.Date, time and pertinent details of the event and subsequent assessment in the medical record.The time the Physician.was contacted.and whether or not orders were received.A review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised [DATE] indicated, The Facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety.needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.A review of the facility's P&P titled Medication- Administration revised [DATE] indicated, All medication shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations.The time and dose of the medication or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the medication or treatment.