

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Woodcrest Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8133 Magnolia Avenue Riverside, CA 92504	

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)
<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240</p> <p>Based on interview and record review, the facility failed to provide cardiopulmonary resuscitation (CPR - a way to help a person who has stopped breathing, and whose heart may have stopped beating, to stay alive) for one of two sampled residents (Resident 1), when Resident 1 was found unresponsive.</p> <p>This failure resulted in Resident 1 not receiving the necessary life saving measures.</p> <p>Findings:</p> <p>On [DATE], and 10, 2024, unannounced visits were conducted at the facility to investigate an allegation of neglect.</p> <p>A record review of Resident 1's medical record indicated Resident 1 was initially admitted to the facility on [DATE], with diagnoses which included atrial fibrillation and hypertension. A review of Resident 1's History and Physical indicated that Resident 1 has the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS - an assessment tool) dated [DATE], indicated Resident 1 was a full code (full support which includes cardiopulmonary resuscitation-CPR, if the patient has no heartbeat and is not breathing).</p> <p>Further review of Resident 1's Progress Note indicated Resident 1 was transferred to (name of general acute care hospital) on [DATE], for bloody sputum and Resident 1 came back to the facility on [DATE].</p> <p>On [DATE], at 1:47 p.m., during an interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated if a resident was a full code and found unresponsive, CPR should be initiated, 911 (universal emergency number) should be called and the medical doctor (MD) should be informed.</p> <p>On [DATE], at 2:04 p.m., during an interview with Registered Nurse (RN) 1, RN 1 stated if a resident was a full code and was found unresponsive, with no pulse and no respirations, CPR should be initiated. RN 1 stated other tasks such as calling 911, notifying the doctor and family are delegated to other staff members.</p> <p>(continued on next page)</p>

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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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE], at 11:27 a.m., during an interview with LVN 2, LVN 2 stated she was the charge nurse for Resident 1. LVN 2 stated on [DATE], Resident 1 had just been readmitted to the facility. LVN 1 stated she gave Resident 1 medications that were due at 5:00 p.m., and Resident 1 took the medications with no difficulty. LVN 2 stated at 8:48 p.m. she came to Resident 1's room to check her blood sugar but Resident 1 did not respond, was without a pulse and was not breathing. LVN 2 stated Resident 1's body was already cold and stiff. LVN 2 stated Resident 1 did not have a completed POLST in her chart making her a full code. LVN 2 stated she did not initiate CPR because Resident 1's body was cold and already stiff. LVN 2 stated she should have initiated CPR.</p> <p>On [DATE], at 11:45 a.m., during an interview with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was assigned to Resident 1 on [DATE]. CNA 1 stated she was with Resident 1 between 6:30 p.m. and 7:00 p.m. CNA 1 stated that was the last time she saw Resident 1 alive. CNA 1 stated she took her break from 7:30 p.m. and 8:00 p.m., and when she returned from her break, she saw two CNAs changing Resident 1. CNA 1 stated she found out Resident 1 had passed away when the Director of Nursing (DON) spoke to her later that night.</p> <p>On [DATE], at 12:02 p.m., during an interview with RN 2, RN 2 stated she was the Supervisor at the facility for the ,d+[DATE] shift on [DATE]. RN 2 stated LVN 2 informed her Resident 1 had passed away at 8:58 p.m. RN 2 stated Resident 1 had no pulse, no respirations, no signs of life and body was already cold and not so stiff. RN 2 stated LVN 2 did not want to do CPR; and RN 2 stated she did not want to do CPR because Resident 1's body was already cold and there was nothing else could be done to revive her. RN 2 stated she called the physician within five minutes and informed him of Resident 1's condition. RN 2 stated, the physician pronounced Resident 1 dead. RN 2 further stated performing CPR would have been adding more insult to injury and not allowing Resident 1 to die with dignity.</p> <p>On [DATE], at 5:25 p.m. during an interview with RN 3, RN 3 stated she would perform CPR, get the crash cart, call 911 if a resident was full code, found unresponsive with no pulse, no respirations and body was cold and stiff. RN 3 stated she heard that there was an unresponsive resident in the facility that was a full code, but CPR was not initiated. RN 3 stated CPR should have been initiated on that resident.</p> <p>On [DATE], at 7:44 p.m., during an interview with the DON, the DON stated they do not have a written policy for CPR. The DON stated staff follows the POLST of residents in their charts. The DON stated if a resident was found unresponsive, staff should assess, check the POLST, page code blue (a code that someone has gone into respiratory or cardiac arrest) three times, initiate CPR if resident was full code and call 911. The DON stated she was notified on [DATE], between 9:20 pm and 9:30 p.m. that Resident 1 passed away. The DON stated LVN 2 and RN 2 were terminated on [DATE], because of lack of judgment when they did not perform CPR to Resident 1. The DON stated LVN 2, or RN 2 should have initiated CPR on Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy and procedure titled, Emergency Procedure- Cardiopulmonary Resuscitation, revised February 2018, indicated, Policy Statement. Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. General Guidelines .If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR .Emergency Procedure. 1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely begin, CPR: a. Instruct a staff member to activate the emergency response system (code) and call 911 .c. Verify or instruct a staff member to verify the DNR or code status of the individual. d. Initiate the basic life support (BLS) sequence events .8. Continue with CPR/BLS until emergency medical personnel arrive.</p>