STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055559	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Crest Care Center	3750 Garnet Street Torrance, CA 90503

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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were developed with interventions for care for two of two sampled residents (Resident 1 and Resident 3) who had indwelling urinary catheters (a hollow tube inserted into the bladder to drain or collect urine) in place. These deficient practices resulted in the care needs related to the use of an indwelling urinary catheter being unknown/undocumented and had the potential for risk associated with the catheter's use such as displacement, urine retention and infection to go unmonitored and unrecognized. Findings: a. During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including fracture (a break in the bone) of the neck, quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and a sacral pressure ulcer (an open wound on the tailbone area caused by constant pressure on the skin, cutting off blood flow and damaging the tissue). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 6/30/20252025, the MDS indicated Resident 1 was able to make decisions that were consistent and reasonable and he a two or more person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 1 was incontinent (loss of full control) of his bowel function and had an indwelling urinary catheter in place. During a review of Resident 1's Order Summary (Physician's Orders) dated 6/26/2025, the Physician's Order indicated the following: 1. Placement of an indwelling urinary catheter, catheter size 18 French ([Fr] a unit of measurement), balloon size: 10 cubic centimeter ([cm] a unit of volume in the metric system), for BPH 2. Change for blockage (a physical obstruction or something that stops the normal flow), leaking, if pulled out, and excessive sedimentation (presence of solid particles suspended in the urine making the urine appear cloudy and murky). 3. Change the catheter drainage bag (a collection bag for urine which is attached to the catheter) as needed and every time the indwelling catheter is changed. During a review of Resident 1's Medical Record (Care Plans) there was no documentation to indicate a Care Plan had been created for the use of Resident 1's urinary indwelling catheter. b. During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis including malignant neoplasm of the prostate (cancer of the prostate) and cystitis (an inflammation of the bladder caused by a bacterial infection). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was able to make decisions that were consistent and reasonable, and he required a two or more person assist to complete his ADLs. The MDS indicated Resident 1 was incontinent of his bowel function and had a indwelling urinary catheter in place. During a review of Resident 3's Physician's Order dated 7/15/2025, the Physician's Order indicated placement of an indwelling urinary catheter, catheter size 18 Fr with a 10 cc balloon secured to the bedside for straight drainage (a continuous flow) for severe cystitis During a review of Resident 3's Medical Records (Care Plans), there was no documentation to indicate a Care Plan had been created for the use of Resident 3's indwelling urinary catheter. During an interview on 8/18/2025 at 1:22 p.m., Licensed Vocational Nurse (LVN) 3 stated a Care Plan should have been created for the use of Resident 1 and Resident 3's indwelling urinary catheters so that care instructions to monitor, document and report to the physician signs of infection and/or complications were in place. During an interview on 8/19/2024 at 3:43 p.m. , the Director of Nursing (DON) stated care plan's were resident centered and must be formulated to fit each resident's needs with a goal to provide care and treatment geared for the resident's safety and well-being. During a review of the facility's Policy and Procedure (P/P) titled, Care Plan Comprehensive dated 8/25/2021, the P/P indicated the facility shall ensure a comprehensive care plan for each resident to include measurable objectives and timetables to meet the residents' medical, physical, mental and psychological needs.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety 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. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure, when a resident was found unresponsive and pulseless (no detectable heart beat), the nursing staff immediately initiated basic life support ([BLS] care healthcare professionals provide to anyone who's heart stops beating suddenly) by performing cardiopulmonary resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) to one of five sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nursing Assistant (CNA) 1, who was CPR certified (successfully completed a training course and received a credential that qualifies a person to perform CPR), checked Resident 1's pulse when on [DATE] at approximately 4:50 a.m. Resident 1 was found unresponsive and not breathing, called for help, activated Code Blue (a specific code used to signal a patient who is having a life-threatening medical emergency, typically a patient experiencing sudden cardiac arrest [when the heart stops beating] or respiratory arrest [when a person stops breathing]), initiated CPR and stayed with Resident 1 per the facility's policy and procedure (P&P) titled, Emergency Procedure-Cardiopulmonary Resuscitation, and the American Heart Association (AHA) Guidelines. 2. Ensure Licensed Vocational Nurse (LVN) 1 immediately initiated CPR when she found Resident 1 was unresponsive, without a pulse and not breathing, instead of leaving the resident's room to get her personal blood pressure (BP) machine (a device that measures a person's BP) from the medication cart, which lost critical time needed to increase Resident 1's chance of survival. 3. Ensure LVN 1 placed Resident 1 in a flat position on his back prior to beginning chest compressions (the act of applying pressure to someone's chest to help blood flow), according to the American Red Cross guidelines that indicate to place the person on their back on a firm, flat surface. 4. Ensure staff called 911 as soon as Resident 1 was found unresponsive and pulseless on [DATE] at 4:50 a.m., per the facility's P&P titled, Emergency Procedure-Cardiopulmonary Resuscitation and the American Red Cross guidelines that indicated if the person does not respond and is not breathing or only gasping to call 911. 5. Ensure CNA 1 and LVN 1 followed the facility's P&P titled, Emergency Cardiopulmonary Resuscitation, which indicated to initiate CPR if sudden cardiac arrest is likely. These failures resulted in: 1. A delay in providing CPR to Resident 1 who was found unresponsive and not breathing on [DATE] at approximately 4:50 a.m. 2. A delay in calling 911 when CNA 1 and LVN 1 found Resident 1 on [DATE] at 4:50 a.m., unresponsive with no chest rising and was not breathing. Resident 1 was pronounced dead on [DATE] at 5:05 a.m. These failures place 66 residents, who were Full Code (a medical term indicating a patient's consent to receive all possible life-saving measures in the event of a cardiac or respiratory arrest) at risk of not receiving basic life saving measures timely, including CPR, leading to possible death. On [DATE] at 12:35 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility'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) was called in the presence of the Director of Nursing (DON), Registered Nurse Supervisor (RNS) and the Administrator (over the phone) due to the facility's failure to provide timely basic life support (BLS), to Resident 1, including immediate initiation of CPR. An IJ Removal Plan ([IJRP], an intervention to immediately correct the deficient practices) was requested. On [DATE] at 10:18 a.m., the DON submitted an acceptable IJRP. After onsite verification of IJRP implementation through observation, interview, and record reviews, the IJ was removed on [DATE] at 1:57 p.m., in the presence of the ADM, the DON and the Director of Staff Development (DSD). The IJRP included the following: 1. On [DATE], the DON conducted an audit of residents with Full Code status. There were 66 residents with full code status. 2. On [DATE], the DON conducted an audit for the past 30 days of expired residents (a resident who has died). Based on the audit, three residents (including Resident 1) expired, 2 out of 3 residents were Full Code and 1 resident was Do Not Resuscitate ([DNR] resident will not receive CPR or other life-saving measures if their heart or breathing stops). Two residents (1 Full Code and 1 DNR) were not affected by the alleged deficient practice. 3. On [DATE], the DON/Designee provided a 1:1 in-service (training or coaching session for a single employee) to CNA 1 on the P&P titled Emergency Procedure-Cardiopulmonary Resuscitation, with emphasis on not leaving resident unattended when unresponsive and to check resident's carotid (under the angle of the jaw) pulse. CNA 1 will activate Code Blue by yelling/screaming for help and place resident in a supine (flat) position, and initiate CPR immediately. The second responder will call 911. 4. On [DATE], the DON/Designee provided a 1:1 in-service to LVN 1 on the P&P titled Emergency Procedure-Cardiopulmonary Resuscitation, with emphasis on not

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was assisted to turn and reposition every two hours, as ordered by Resident 1's physician, and per Resident 1's care plan. This deficient practice resulted in Resident 1 not being turned or repositioned for approximately five hours on 8/4/2025 and had the potential for delay in healing, increase to Resident 1's sacral (tailbone) pressure sore ([bedsore] an open wound on the tailbone caused by constant pressure on the skin, cutting off blood flow and damaging the tissue) and/or the development of new pressure sores.Findings During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including a cervical spine fracture (broken neck), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and a sacral pressure ulcer. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 6/30/20252025, the MDS indicated Resident 1 was able to make decisions that were consistent and reasonable, and he required a two or more person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily. During a review of Resident 1's Order Summary Report (Physician's Order), the Physician's Order indicated to offload pressure (to reduce or remove the weight and pressure from a wound to allow blood flow, healing and repair) from his pressure sore and to turn Resident 1 every two hours. During a review of Resident 1's untitled Care Plan dated 7/31/2025, the Care Plan indicated Resident 1 had a community acquired Sacro coccyx pressure injury related to decreased mobility. The Care Plan's goal indicated that Resident 1 would be free from any complications related to pressure injuries with interventions that included monitoring Resident 1's skin for further breakdown during ADL care such as turning and repositioning. During a review of Resident 1's Documentation Survey Report 2 dated 8/2025, the Documentation Survey Report 2 indicated the turning and or repositioning section dated 8/3/2025 to 8/4/2025 during the at 11 p.m. to 7 a.m. shift was blank (no documentation from the nursing staff). During a telephone interview on 8/15/2025 at 12:30 p.m., Certified Nursing Assistant (CNA) 1 stated she was no sure if Resident 1 had pressure sores or if he needed to be turned/repositioned in bed. During a subsequent telephone interview on 8/18/2025 at 12:20 p.m., CNA 1 stated she did not turn and/or reposition Resident 1 after midnight on 8/4/2025 during the 11 p.m. to 7 a.m. shift because Resident 1 was asleep and always refused to be turned anyway. During an interview on 8/18/2025 at 12:54 p.m., CNA 3 stated Resident 1 had to be turned and repositioned every two hours during all shifts because he had a bed sore on his bottom. CNA 3 stated Resident 1 never refused to be turned/repositioned and was always willing to participate in his care. During an interview on 8/19/2025 at 3:43 p.m., the Director of Nursing (DON) stated residents' care and provision of ADLS such as turning and/repositioning involved not only providing comfort to the resident but also an assessment of the resident's skin integrity and a direct observation of the residents' situation to identify any possible change in conditions (COC) or emergencies. The DON stated CNA 1 should have provided ADL care, turned/repositioned Resident 1 and documented in Resident 1's medical record the care that was provided to Resident 1. During a review of the facility's Policy and Procedure (P/P) titled, Repositioning revised 5/2013, the P/P indicated the following: a. Repositioning is an effective intervention for preventing skin breakdown, promoting circulation and providing pressure relief and is critical for a resident who is immobile or dependent upon staff for repositioning. b. Repositioning the residents promote comfort for residents who are bed-chair-bound, and c. The frequency of turning/repositioning of the residents who are bed or chair bound should be at least on an every 2 hour schedule. During a review of the facility's P/P titled, Activities of Daily Living (ADLs), Supporting revised 3/2018, the P/P indicated the facility shall provide residents with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. The P/P indicated the residents who are unable to carry out activities of daily living independently will receive care and services necessary to maintain good nutrition, and hygiene to include but not limited to turning and repositioning.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure turning an repositioning of a resident, along with the sequence of events related to the performance of cardiopulmonary resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) was accurately documented for one of five sampled residents (Resident 1), when Resident 1 was found unresponsive and pulseless (no detectable heart beat) on [DATE]. These deficient practices resulted in the inability to determine if Resident 1 was turned and/or repositioned on [DATE] to [DATE] during the 11 p.m. to 7 a.m. and an inaccurate depiction (shown in a particular way through a description) of CPR performed on Resident 1 by LVN 1 and had the potential for the investigation into care provided to Resident 1 and his subsequent death to be skewed (slanted away from what is true or normal. Findings: a. During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including cervical spine fracture (broken neck), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing), and a sacral pressure ulcer (an open wound on the tailbone area caused by constant pressure on the skin, cutting off blood flow and damaging the tissue). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated [DATE], the MDS indicated Resident 1's cognition (ability to think, understand, and remember) was intact, he had the ability to understand and be understood by others. The MDS indicated Resident 1 was fully dependent on staff (requiring a two or more person assist to complete the activity) for activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) and he was incontinent (loss of full control) of his bowel function and had an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). During a review of Resident 1's Order Summary Report (Physician's Order) dated [DATE], the Physician's Order indicated to offload pressure (to reduce or remove the weight and pressure from a wound to allow blood flow, healing and repair) from Resident 1's pressure sore and to turn Resident 1 every two hours. During a review of Resident 1's Documentation Survey Report 2, dated 8/2025, the Documentation Survey Report 2 indicated documentation for personal hygiene and/or toileting, turning and/or repositioning on [DATE] to [DATE] during the 11 p.m. to 7 a.m. shift was blank. During a telephone interview on [DATE] at 12:20 p.m., Certified Nursing Assistant (CNA) 1 stated she did not turn and/or reposition Resident 1 after midnight on [DATE] during the 11 p.m. to 7 a.m. shift because Resident 1 was asleep and he always refused to be turned anyway. CNA 1 stated she tried to document in Resident 1's medical record, but her documentation was not reflected in Resident 1's chart. CNA 1 stated it was her responsibility to document and/or update the residents' medical record to reflect the actual care provided to the residents. During an interview on [DATE] at 10 a.m., the Director of Staff Development (DSD) stated CNAs are required to document the care and services provided to residents, and residents' non-compliance to ensure licensed nurses were informed of a potential change in condition (COC) and to monitor the residents' behavior. During a subsequent record review and interview with the DSD on [DATE] at 11:01 a.m., the DSD confirmed and stated Resident 1's medical record titled, Documentation Survey Report 2 indicated Resident 1's ADLs task with bed mobility, personal hygiene/ toileting and repositioning and turning every two hours on [DATE] and [DATE] during the 11 p.m. to 7 a.m. shift, was blank During an interview on [DATE] at 3:43 p.m., the Director of Nursing (DON) stated there was no excuse for CNA 1 not to document in Resident 1's medical record because it was her responsibility to indicate the actual care provided to Resident 1 and to relay the information to the nursing team to prevent delay in care and services. During a review of the facility's Policy and Procedure (P/P) titled Charting and Documentation revised 7/2017, the P/P indicated all services provide to the resident, progress toward care plan goals, or any changes in the residents' medical, physical, functional, or psychosocial condition, shall be documented in the residents' medical record to facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. During a review of the facility's Certified Nursing Assistant (CNA) Job Description revised 10/2020, the CNA Job Description indicated the CNA shall provide residents with routine care and services including but not limited to recording all of the residents' entries on flow sheets, notes and/or chart in a descriptive manner and to report all changes in condition to the charge nurse and/or charge nurse supervisor. b. During a review of Resident 1's Nurses Progress Notes dated [DATE] and timed at 5:10 a.m., the Nurses Progress

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a QA/QAPI ([Quality Assurance/Quality Assurance and Performance Improvement] a data driven proactive approach to improvement used to ensure services are meeting quality standards) was implemented to verify the nursing staff's competency skills in performing cardiopulmonary resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) when residents' are found unresponsive and pulseless (no detectable heart beat). This deficient practice resulted in a delay in providing CPR to Resident 1 and calling 911 when Resident 1 was found unresponsive and not breathing on [DATE] at approximately 4:50 a.m., and subsequently pronounced dead on [DATE] at 5:05 a.m. This deficient practice placed 66 residents, who were Full Code (a medical term indicating a patient's consent to receive all possible life-saving measures in the event of a cardiac or respiratory arrest) at risk of not receiving basic life saving measures timely, leading to possible death.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including cervical spine fracture (broken neck), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury [the conduit {tube} between the brain and the rest of the body]), and chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated [DATE], the MDS indicated Resident 1's cognition (ability to think, understand, learn, and remember) was intact and he had the ability to understand and be understood by others. The MDS indicated Resident 1 was fully dependent on staff (requiring two or more-person assistance to complete the activity) for activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's History and Physical (H&P) dated [DATE], the H&P indicated Resident 1 had the capacity to understand and make decisions. The H&P indicated Resident 1 was a Full Code status. During a review of Resident 1's Physician Orders for Life Sustaining Treatment ([POLST] a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life) dated [DATE], the POLST indicated if Resident 1 had no pulse and was not breathing to attempt resuscitation/CPR. During a review of Resident 1's Nurses Progress Notes dated [DATE] and timed at 5:10 a.m., the Nurses Progress Notes indicated CNA 1 notified LVN 1 that Resident 1 was unresponsive on [DATE] at 4:50 a.m., LVN 1 went to assess Resident 1 and found him with absent vital signs ([v/s] measure the basic functions of the body which include temperature, blood pressure, pulse and respiratory [breathing] rate). The Nurses Progress Notes indicated LVN 1 initiated chest compressions and sent CNA 1 to get LVN 2, Code Blue was initiated. The Nurses Progress Notes indicated LVN 2 took over the Code Blue with assistance from CNA (CNA) 2, 911 was called at 4:57 a.m. (seven minutes after CNA1 and LVN 1 found Resident 1 was found unresponsive), paramedics (a highly trained healthcare professional who provides advanced emergency medical care) arrived at 5:05 a.m., assessed Resident 1, who had absent v/s and was not breathing. During a review of Emergency Medical Service Report ([EMS] a detailed document completed by emergency medical personnel that serves as a record of a patient's pre-hospital assessment and the care they received), dated [DATE] and timed at 5:05, the EMS Report indicated paramedics were called on [DATE] at 4:57 a.m. (seven minutes after Resident 1 was found unresponsive and without a pulse) and arrived on [DATE] at 5:05 a.m., where they found Resident 1 deceased . During a telephone interview on [DATE] at 2:20 p.m., and a subsequent interview at 5:20 p.m., CNA 1 stated on [DATE] around 4:45 a.m., during her rounds, she walked into Resident 1's room and did not see Resident 1's chest rising (not breathing). CNA 1 stated she did not check Resident 1's pulse when she found Resident 1 not breathing. CNA 1 stated she did not initiate CPR immediately and left Resident 1 unattended to get LVN 1, who was at Nursing Station 2. CNA 1 stated she did not initiate CPR immediately because she wanted a witness and it was her first time experiencing an unresponsive resident. During an interview on [DATE] at 3 p.m., LVN 2 stated on [DATE] she was informed by CNA 1 that LVN 1 needed help. LVN 2 stated when she entered Resident 1's room, she saw LVN 1 on top of Resident 1's bed on her knee but she did not see LVN 1 performing chest compressions on Resident 1. LVN 2 stated Resident 1 did not have a pulse, so she initiated chest compressions and directed LVN 1 to get the crash cart (a set of trays/drawers/shelves on wheels used in hospital or skilled nursing facility for transportation and dispensing of emergency medication/equipment at