STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056074	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chico Heights Rehabilitation & Wellness Centre, L	587 Rio Lindo Avenue Chico, CA 95926

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** 43739 Based on interview, and record review, the facility failed to immediately initiate Basic Life Support (BLS) including Cardiopulmonary Resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) when one of three sampled full code (as full support which includes cardiopulmonary resuscitation, if the patient has no heartbeat and is not breathing) residents (Resident 1) was found unresponsive and without a pulse in his bed, and staff took 10 minutes to start CPR on Resident 1. These deficient practices had the potential to delay provisions of emergency care for current residents who wish to have full treatments in a life-threatening situation. Findings: During a review of American Heart Association website page titled, What is CPR, indicated that CPR is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances of survival after cardiac arrest. During a review of American Heart Association Basic Life Support (BLS) healthcare provider adult cardiac arrest algorithm, dated 2020, indicated: 1. First step: Check for responsiveness. Shout for nearby help. Activate emergency response system via mobile device (if appropriate). Get Automated External Defibrillator (AED - a medical device used to treat cardiac arrest) and emergency equipment (or sent someone to do so). 2. Second step: Look for no breathing or only gasping and check pulse (simultaneously). Is pulse definitely felt within 10 seconds? (continued on next page)

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Third step: If no normal breathing, pulse felt provide rescue breathing, 1 breath every 6 seconds or 10 breaths/min. Check pulse, start CPR. During a review of the facility ' s policy titled, Cardiopulmonary Resuscitation, revised [DATE], indicated: 1. The purpose is to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel, and subject to related physician orders, and the resident ' s advance directives/expressed wishes. 2. The facility ' s procedure for administering CPR shall incorporate the guidance from the current standards established by the American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or facility BLS training material. 3. If an individual is found unresponsive with no pulse and respirations, a staff member who is certified in CPR/BLS shall initiate CPR. 4. Responding to Cardiopulmonary Emergency - If the victim is unresponsive (no movement or response to stimuli, and no pulse or respirations, activate the Emergency response team). - Call for help and send someone to contact the Emergency Medical Services (EMS) OR 911 for emergency medical assistance. - Send someone for the emergency cart and supplies, and to announce your facility code for medical emergencies. - Initiate CPR in accordance with American Heart Association guidelines. - Continue CPR until the EMS arrives and assumes care of the resident. During a review of the facility ' s policy titled, Death of a Resident, revised [DATE], indicated: 1. Only a Licensed Physician may declare a resident dead. The licensed Nurse will report the resident ' s symptoms to the Attending Physician so the Attending Physician can make an official determination of death. 2. The procedure for Unexpected Death and Resident is a Full Code is that the nursing staff will use CPR and call 911 to request transport for the resident to an acute care hospital. Nursing staff will notify the Attending Physician and the resident ' s family immediately. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s clinical record, the record indicated, Resident 1 was initially admitted to the facility [DATE]. He was readmitted to the facility, on [DATE], with diagnoses which included dysphagia (difficulty swallowing) following cerebral infarction (ischemic stroke-the blood supply to part of the brain is blocked or reduced stroke), other abnormalities of gait and mobility, and need for assistance with personal care. Resident 1 and Resident 1 ' s spouse were Resident 1 ' s health care decision makers. During a review of Resident 1 ' s physician order, dated [DATE], indicated that Resident 1 was full code with full treatment, long term means of artificial nutrition including feeding tubes in the event of a life-threatening situation. During a review of Resident 1 ' s clinical record titled, Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE], the record indicated, Resident 1 chose to have Cardiopulmonary Resuscitation in the event of no pulse and is not breathing. During a review of Resident 1 ' s progress note, dated [DATE] at 9:24 pm by Licensed Nurse (LN) A, indicated that LN A found Resident 1 had an unexpected death on [DATE] at 5:45 pm. The note indicated: 1. At 5 pm, Resident 1 was last seen alive at 5 pm while he was changed by a Certified Nursing Assistant (CNA). 2. At 5:45 pm, - LN A found Resident 1 was unresponsive and pulseless; CPR was not initiated. - LN A went out the room and ask a nurse to go inside Resident 1 ' s room, because Resident 1 had passed away. Both LN A and the nurse did not initiate CPR. - LN A then went to check Resident 1 ' s code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) and found Resident 1 was full code. LN A then had another nurse call for Registered Nurse. 3. At 5:55 pm, LN A started chest compression. 10 minutes after LN A initially found Resident 1 was unresponsive and pulseless. 4. At 6 pm, code blue (generally used to indicate a patient requiring resuscitation or otherwise in need of immediate medical attention) call was placed over intercom. 5. At 6:01 pm, the nurse called Emergency Medical Services (EMS) for emergency assistance. 6. At 6:07 pm, EMS arrived and took over CPR. EMS continued with life sustaining treatment for Resident 1. 7. At 6:30 pm, EMS stopped CPR. 8. At 6:35 pm, Resident 1 was pronounced dead. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:16 pm with the Director of Nursing (DON), the DON stated the expectation for the nursing staff to initiate CPR is immediately. The DON stated LN A was following the facility ' s policy to verify the time of the death of Resident 1 with another licensed nurse. However, upon reviewing the facility ' s policy, no such policy was located, and the facility ' s policy titled, Death of a Resident, indicated that only a Licensed Physician may declare a resident dead. During an interview on [DATE] at 12:15 pm with LN A, 1. LN A stated that on [DATE] at 5:45 pm, LN A went into Resident 1 ' s room, he found Resident 1 unresponsive and pulseless. LN A went to grab another nurse, the Director of Staff Development (DSD), to check Resident 1 and DSD told LN A that Resident 1 was dead. LN A then ran to his cart to find out Resident 1 was full code. LN A went to LN C, LN C activated Code Blue and called EMS. LN A stated the CPR started at 17:55 pm. LN A confirmed that CPR did not started timely as it should have. 2. LN A stated that he wished he would have known Resident 1 code status on top of his head, so he could initiate the CPR immediately. During an interview on [DATE] at 10:55 am with LN B, 1. LN B stated the facility recently just had BLS in-service in [DATE]. LN B stated, in the BLS class, we learned that everyone should know the code status of all your residents. if you came into a room and you find someone had no pulse, no breathing, you should start CPR immediately and then you yelled for someone like go check the code status, called a code blue. You were not supposed to leave the residence. 2. LN B stated, It ' s not my scope of practice to decide who ' s dead and who's not you don ' t call it. It always will be the physician to make that call. 3. LN B stated that LN A grabbed the DSD to check on Resident 1, and the DSD did not know that she needed to start CPR, LN B said, like nobody knew that they needed to start CPR. It ' s like there ' s literally this many people did not know that they need to start CPR if you found someone without a pulse and respiration, there ' s something wrong .

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview, and record review, the facility failed to comply with applicable Federal, State, and local laws, regulations, and with accepted professional standards and principles for one of three sampled residents (Resident 1) when: 1. The administrator (ADMIN) requested Registered Nurse (RN) D to reword her progress note. 2. The administrator directed Licensed Nurse (LN) B to change LN A ' s progress note. 3. The administrator directed LN A to redraft his progress note, because the time on the note was showing the delay of the care. These failures had the potential to inaccurately document the care provided to all the residents, and the inappropriate care services go undetected and unreported to the authorities. Refer to F 678. Findings: During a review of California Penal Code, Section 471.5, indicated, Any person who alters or modifies the medical record of any person, with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor. During a review of the facility ' s document titled, Administrator job description, indicated that the ADMIN ' s principal responsibilities and duties include, Directing and monitoring compliance with federal and state regulations and laws, and the ADMIN ' s qualifications include, Current Knowledge of local, state, and federal guidelines and regulations. During a review of the facility ' s policy titled, Completion & Correction, Medical Records Manual - General, revised [DATE], indicated: 1. The purpose is to ensure that medical records are complete and accurate. 2. The Facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. 3. Only Facility Staff who are credentialed and/or have the authority to do so may document in the medical record of a resident. 4. Entries will be complete, legible, descriptive, and accurate. 5. Any person (s) making observations or rendering direct services to the resident will document in the record. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Documentation will reflect medically relevant information concerning the resident and will be documented in a professional manner. 7. Clarification is a type of late entry used to clarify a previous entry to avoid incorrect interpretation of information that has been previously documented and should include the following: - The current date and time. - Designate the information as clarification and state the reason for the clarification referring back to the original entry. - Sources of information are identified when used to support the clarification. During a review of the facility ' s policy titled, Progress Notes, revised [DATE], indicated: 1. Each discipline will be responsible for documenting the resident ' s progress according to Federal and State regulations and Facility policy. 2. All disciplines at the Facility will document progress notes in the appropriate section of the resident ' s medical record according to professional stands and regulations. 3. Progress notes will reflect the resident ' s current status, progress or lack of progress, changes in condition, adjustment to the Facility, and other relevant information. During a review of the facility ' s policy titled, Cardiopulmonary Resuscitation (CPR - an emergency procedure used to restart a person ' s heartbeat and breathing after one or both have stopped. It involves giving strong, rapid pushes to the chest to keep blood moving through the body), revised [DATE], at the section of Documentation, indicated: 1. Utilize CPR flowsheet to record the events of the resident emergency. 2. Document in the resident ' s medical record the event of Cardiopulmonary Resuscitation: - The condition the resident was found, or the witnessed event. - Vital signs, including blood pressure, [NAME], respiration, and oxygen saturation. - The time the resident was found and the time when CPR was started. - Any other measures taken such as administration of oxygen and liter flow, and blood sugar results if obtained, etc. - The resident ' s response to CPR. - Time Emergency Medical Services (EMS) arrived and assumed care for the resident. - The final disposition of the resident. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Notification of the attending physician. - Notification of resident representative. During a review of Resident 1 ' s clinical record, the record indicated, Resident 1 was initially admitted to the facility [DATE]. He was readmitted to the facility, on [DATE], with diagnoses which included dysphagia (difficulty swallowing) following cerebral infarction (ischemic stroke-the blood supply to part of the brain is blocked or reduced stroke), other abnormalities of gait and mobility, and need for assistance with personal care. Resident 1 and Resident 1 ' s spouse were Resident 1 ' s health care decision makers. During a review of Resident 1 ' s clinical record titled, Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE], the record indicated, Resident 1 chose to have Cardiopulmonary Resuscitation in the event of no pulse and is not breathing. During a review of Resident 1 ' s progress note, dated [DATE] at 12:41 pm by RN D, indicated that RN D made strikethrough mark on her original note and created another note below. One of the sentences in the original note, went to the resident ' s room with the Responsible Party (RP) to check Resident 1 ' s wellbeing and the RP instructed the Certified Nursing Assistant (CNA) in charge at that time to sit Resident 1 on semi-Fowler ' s (Semi-[NAME] position is a position in which the individual lies on their back on a bed with the head of the bed elevated at ,d+[DATE] degrees) so to prevent asphyxiation (deprivation of oxygen that can result in unconsciousness and often death) . was noticed to change to, went to the resident ' s room with the Responsible Party (RP) to check Resident 1 ' s wellbeing and the RP instructed the CNA in charge at that time to sit Resident 1 on semi-Fowler ' s for reposition . The reason for changing it was incorrect documentation. During a review of Resident 1 ' s progress note, dated [DATE] at 9:24 pm by LN A, indicated that LN A found Resident 1 had an unexpected death on [DATE] at 5:45 pm. The note indicated: 1. At 5 pm, Resident 1 was last seen alive at 5 pm while he was changed by a CNA. 2. At 5:45 pm, LN A found Resident 1 was unresponsive and pulseless in the bed. LN A went out the room and ask a nurse to go inside Resident 1 ' s room, because Resident 1 had passed away. LN A then went to check Resident 1 ' s code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) and found Resident 1 was full code (as full support which includes cardiopulmonary resuscitation, if the patient has no heartbeat and is not breathing). LN A then had another nurse call for Registered Nurse. 3. At 5:55 pm, LN A started chest compression. 10 minutes after LN A found Resident 1 unresponsive and pulseless. 4. At 6 pm, code blue (generally used to indicate a patient requiring resuscitation or otherwise in need of immediate medical attention) call was placed over intercom. 5. At 6:01 pm, the nurse called EMS for emergency assistance. 6. At 6:07 pm, EMS arrived and took over CPR. EMS continued with life sustaining treatment for Resident 1. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. At 6:30 pm, EMS stopped CPR. 8. At 6:35 pm, Resident 1 was pronounced dead. During a concurrent interview and record review on [DATE] at 7:25 am with LN B, Resident 1 ' s Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work together to provide the care the patient needs) progress note, dated [DATE] at 4:09 pm, was reviewed. 1. LN B stated that she was called into the facility ' s conference room on [DATE], and the ADMIN asked LN B to edit an IDT progress note for Resident 1 for the unexpected death that happened on [DATE]. The ADMIN said to LN B, Because you wrote good notes . LN B told the ADMIN that she was not there when it happened, and she wouldn ' t know the detail. The ADMIN told LN B, just write it. While LN B was writing the note, the ADMIN asked LN B to retype the note the way the ADMIN described LN B to write. 2. LN B stated that while she was editing the IDT note, the ADMIN asked LN B to alter LN A ' s progress note that was dated [DATE] at 9:24 pm, LN B refused and said to the ADMIN, No, I could not do that, not only was it illegal, the PointClickCare (PCC - is a cloud-based Electronic Health Record software platform tailored for long-term care providers, including skilled nursing facilities .) won ' t let you do it . During a concurrent interview and record review on [DATE] at 12:15 pm with LN A, a document titled, Reporting, [DATE] Unusual Occurrence Unexpected Death, described the event of Resident 1 ' s unexpected death on [DATE] with the ADMIN ' s name typed at the bottom of the document was review. LN A stated: 1. On [DATE] at 5:45 pm, LN A went into Resident 1 ' s room, he found Resident 1 unresponsive and pulseless. LN A went to grab another nurse, the Director of Staff Development (DSD), to check Resident 1 and DSD told LN A that Resident 1 was dead. LN A then ran to his cart to find out Resident 1 was full code. LN A went to LN C, LN C activated Code Blue and called EMS. LN A stated the CPR started at 17:55 pm, exactly how he described in Resident 1 ' s progress note. 2. On [DATE] at 3 pm, LN A was requested to report to the facility and met with the ADMIN. LN A stated that the ADMIN wanted me to redraft my note, she said the time on my note was showing the delay of the care. She handed me a piece of paper and asked me to follow exactly what she wrote on the paper, basically she took away the time. I told her that is not right. I read it, I said OK, but then, I changed my mind, it does not feel right . 3. LN A acknowledged that the document reviewed was the one the ADMIN handed to him, and the document did not show when the CPR was initiated and when EMS was contacted. During a concurrent interview and record review on [DATE] at 11:30 am with RN D, (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. A signed job description for RN D was reviewed. RN D stated that after she came back from maternity leave, she lost her old position as a Minimum Data Set (MDS) nurse (a nurse assessment coordinator, collects and assesses information for the health and well-being of residents in Medicare- or Medicaid-certified nursing homes). While she was attempting to get her old job title back, the ADMIN made her sign a new job description/agreement, on the paper, there were three handwritten sentences with both the ADMIN and RN D signatures, dated [DATE]. One of the sentences indicated that RN D had to do anything what administrator may have requested. 2. RN D stated on [DATE], the ADMIN texted her to go to the conference room, while RN D met with the ADMIN in the conference room, the ADMIN asked RN D to change Resident 1 ' progress note that she wrote on [DATE] at 12:41 pm. The ADMIN told RN D to remove asphyxiation from her note, the ADMIN said to RN D, because I don ' t want them to think like that ' s the reason why he died . 3. RN D appeared to be tearing and distraught. RN D stated, I said, what ' s wrong with my note, it ' s correct. At least I was there with the RP and then we saw that he was crouched. So, we tried to elevate him to prevent asphyxiation . RN D stated that she could not say no to the ADMIN because the ADMIN made her sign the agreement. RN D stated that she was scared of the ADMIN, and she just had a baby, she could not lose her job. During an interview on [DATE] at 12:05 pm with the ADMIN, the ADMIN confirmed that she made RN D change her note. The ADMIN stated that she would ask the staff to clarify and reword the note if she thinks there ' s not enough information.