

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Walnut Creek Skilled Nursing & Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 Rossmoor Parkway Walnut Creek, CA 94595	

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** 32717</p> <p>Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to provide emergency basic life support, including Cardiopulmonary Resuscitation (CPR, any medical intervention used to restore blood circulation or breathing functions that have ceased) to Resident 1 who was found with no pulse and no spontaneous respiration.</p> <p>This failure resulted in the delayed provision of emergency basic life support for Resident 1. Resident 1 was pronounced deceased by emergency personnel at 5:52 a.m., 42 minutes after Resident 1 was found with no pulse.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility in [DATE] with diagnoses that included anoxic brain damage (brain injuries that are caused by a complete lack of oxygen to the brain), dependence on respirator status and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body).</p> <p>During a review of Resident 1's Physician Orders for Life Sustaining Treatment form (POLST, a medical order that tells emergency health care professionals what to do during a medical crisis where the patient cannot speak for him/herself), dated [DATE], Section A indicated to Attempt Resuscitation/CPR.</p> <p>During a review of Resident 1's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 1's code status was FULL CODE (If a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive).</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>During a telephone interview on [DATE] at 12:26 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on [DATE], early morning around 5 a.m., she was in another hallway, away from Resident 1's room when a Certified Nursing Assistant (CNA) called to say Respiratory Therapist (RT) 1 needed help in a Resident 1's room. LVN 1 stated she went to Resident 1's room to find RT 1 alone at Resident 1's bedside, bagging (use of a medical tool, a bag valve mask [BVM] or otherwise known as ambubag, which forces air into the lungs of patients who have either ceased breathing completely or who are struggling to breathe properly and need additional assistance in breathing). LVN 1 stated Resident 1's skin had already turned blue. LVN 1 stated RT 1 asked when LVN 1 had last checked on Resident 1 because RT 1 had been bagging Resident 1 for 15 minutes. LVN 1 stated she asked RT 1 if RT 1 had already called a code (a term used when a patient is in cardiopulmonary arrest [loss of effective heart function, breathing and consciousness] requiring a team of providers, sometimes called a code team, to rush to the specific location and begin immediate resuscitative efforts) but RT 1 did not answer. LVN 1 stated she left the room, called a code, and instructed another staff to call 911 while grabbing the crash cart. LVN 1 stated RT 2, who was the RT assigned to Resident 1, entered Resident 1's room, and stood by RT 1 at the bedside. LVN 1 stated both RT 1 and RT 2 did not start chest compressions on Resident 1. LVN 1 stated after a few seconds, RT 3 and another licensed nurse both entered the room and started chest compressions on Resident 1 while LVN 1 documented the time and sequence of the Code procedure.</p> <p>During a telephone interview on [DATE] at 9:04 p.m. with RT 1, RT 1 stated not knowing who called the code or who called 911. RT 1 stated Resident 1 was breathing fine and was not in respiratory distress, but the ventilator alarms continued to beep so RT 1 called for RT 2 right away. RT 1 could not recall checking if Resident 1 had a pulse.</p> <p>During a telephone interview on [DATE] at 1:11 p.m. with RT 2, RT 2 stated after returning to the unit from break around 5 a.m., RT 1 and LVN 1 were both in Resident 1's room. RT 2 stated being told by RT 1 that Resident 1 had desaturated (oxygen level in the blood is dropped) and had to be given 100% oxygen via BVM. RT 2 stated RT 1 was bagging Resident 1, who did not have a pulse and whose skin color was not good and looked pale. RT 2 stated a Code was called and RT 3 reentered the room and delivered chest compressions with the help of another staff.</p> <p>During a review of Resident 1's Health Status Note, dated [DATE], the Health Status Note indicated the following documentation in the order of the time they were written:</p> <p>1. Incident Note, dated [DATE] at 6:50 a.m. entered by RT 2, the Incident Note indicated at 5:10 a.m., RT 2 was called into Resident 1's room by RT 1, Resident 1 was pale in color and did not have a pulse. Compressions initiated with AED and code blue announced. Nurse called 911. Nurse and RT continued compressions with AED. Paramedics arrived at about 5:20 a.m. and took over. Resident 1 was pronounced expired at 5:52 a.m. See nurses [notes] for further information.</p> <p>2. Health Status Note, dated [DATE] at 7:35 a.m. entered by RT 1, the Health Status Note indicated RT 1 entered Resident 1's room due to ventilator alarms beeping. RT called at 05:10, RT arrived and found with no pulse, Nurse called 911 and compressions /AED initiated with [oxygen] delivery at 100% via bag valve mask. Paramedics arrived around 5:20 and relieved RT and nurses. See nurse notes for more information.</p> <p>(continued on next page)</p>		

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