STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A134	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to provide immediate cardiopulmonary resuscitation (CPR - emergency lifesaving procedure, consisting of a combination of chest compressions, mouth- to-mouth, or mechanical breathing [using a device to help someone breathe], performed when the heart stops beating or beats ineffectively to restore breathing) to one of two sampled residents (Resident 1), who was a full code (when the resident's heart stops beating and/or the resident stops breathing, the resident or their representative's wishes to perform all lifesaving procedures to keep the resident alive, a full code is the default status for all patients unless they have explicitly discussed other wishes with their medical provider). On [DATE], Certified Nursing Assistant 1 (CNA 1), Licensed Psychiatric Technician (LPT 1) and Licensed Vocational Nurse 1 (LVN 1) did not provide CPR immediately when Resident 1 was found unresponsive in Resident 1's room as indicated in the facility's Policy and Procedures (P&P) titled Advance Directives [AD, legal document that provides instructions regarding medical care according to the resident's wishes and only goes into effect if the resident can no longer communicate their wishes]./Individual Health Care Instructions and Emergency Response Policy and Procedure. As a result, on [DATE] at 6:49 am, Resident 1 was pronounced expired after the paramedics (emergency medical technicians [EMT] who provide emergency medical services) performed unsuccessful CPR to Resident 1. On [DATE], while onsite at the facility, the California Department of Public Health (the Department) identified 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) regarding the facility's failure to provide immediate CPR to Resident 1 when Resident 1 was found unresponsive on [DATE], by failing to ensure CNA 1, LPT 1, and LVN 1 performed CPR immediately when Resident 1 was found unresponsive. The surveyor notified the Administrator (ADM), the Director of Nursing (DON), and the Quality Assurance Nurse (QAN) of the IJ situation on [DATE] at 3:22 pm. On [DATE], the facility submitted an acceptable IJ Removal Plan (IJRP, plan that includes interventions to immediately correct the deficient practices). While onsite at the facility, the surveyor determined the IJ situation was no longer present and confirmed/verified the facility's full implementation of the IJRP through observations, interviews, and record review. The IJ was removed on [DATE] at 5:02 pm in the presence of the QAN, and the Program Director (PD). (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJPR included the following immediate actions: On [DATE], 1.The Director of Nursing (DON) and ADM provided in-service education to all nursing staff on duty, this included 3 licensed staff and 10 CNAs. The in-service education lesson plan focused on the protocol for providing CPR to an unresponsive Resident. 2. In-service training included: o Nursing staff first on scene of the unresponsive resident will begin to administer CPR while calling for a Code Blue [an emergency code that used to indicate a patient/resident requiring immediate cardiopulmonary resuscitation] and the location of the resident. o Staff not administering CPR will call 911 immediately. o Nursing staff first on scene will not discontinue CPR until another nursing staff member that is CPR certified takes over doing CPR or paramedics arrive; whichever is first. o Staff is not to leave the unresponsive resident until expiration has been verified by paramedics. Identifying other residents at risk: on [DATE], the DON reviewed all 94 current residents' code status [a type of emergent treatment a person would or would not receive if their heart or breathing were to stop] and documentation of no advanced directive by responsible party was all residents' charts. All 94 current residents are full code status. Root Cause Analysis: on [DATE], the ADM, the DON, and the QAN conducted a root cause analysis, including: 1. Review of interviews with involved staff (CNA 1, LPT 1, LVN 1, HK [housekeeping] 1) 2. Review of facility policies and procedures related to emergency response and CPR. 3. Review of all 75 nursing staff working the floor (20 licensed staff, 51 CNA's, 4 nursing aids) to ensure all were CPR certified, 75 out of 75 nursing staff were CPR certified. The root cause analysis revealed: 1. Lack of clear understanding among all staff regarding their role in initiating CPR. 2. Insufficient emphasis on the immediacy required in emergency situations. Systemic Changes and Preventive Measures: 1. On [DATE], the facility updated its Emergency Response Policy to clearly state that any staff member who discovered an unresponsive resident must immediately alert the nearest nursing staff and remain with the resident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Emergency Medical Technician (EMT, trained medical professional who provides emergency medical care to people outside of a hospital) Fire Department run report (a standard document used by emergency medical service care providers), dated [DATE], timed at 6:36 am, the report indicated EMTs arrived at the facility on [DATE] at 6:43 am and were at Resident 1's bedside to evaluate Resident 1 at 6:44 am. The report indicated the EMTs found Resident 1 on the floor, unresponsive, and pulseless (without a pulse). The report's narrative indicated CPR was given to Resident 1and Resident 1's first monitored heart rhythm (electrical activity of the heart seen on a screen) was asystole (no heartbeat). The report's narrative indicated Resident 1 was dead (expired) prior to the EMTs arrival and the EMTs called a time of death (TOD) at 6:49 am. The report indicated staff alleged had seen Resident 1 ten minutes prior to the EMT's arrival but Resident 1 had rigor (fourth stage of death, recognizable sign of death characterized by stiffening of the limbs caused by chemical changes in the muscles and can occur as soon as four hours after death) and lividity (bluish purple discoloration of the skin after death). During a review of Resident 1's Progress Note (PN) written by LPT 1, dated [DATE], timed at 8:29 am, the PN indicated at 6:25 am, [CNA 1] alerted LPT 1 to check on Resident 1. The PN indicated Resident 1 was found bent over in the corner, between the bed and the closet [in Resident 1's room]. The PN indicated LPT 1 tapped Resident 1 on the back, but there was no response from Resident 1. The PN indicated Resident 1 had no vital signs (measuring the basic functions of your body temperature, blood pressure, pulse, and respirations) and [the staff] called for help, called a code blue, and CPR was started (no time specified). The note indicated paramedics arrived at the facility around 6:30 am (per the EMT report, EMT arrival time was 6:43 am), Resident 1 was pronounced expired, and the coroner's (a person who examines the circumstances surrounding a death) office was called. During a telephone interview on [DATE] at 1:28 pm, with LPT 1, LPT 1 stated CNA 1 informed LPT 1 to check on Resident 1after CNA 1 found Resident 1 unresponsive. LPT 1 stated, LPT 1 was assigned to care for Resident 1 on [DATE] during the night shift. LPT 1 stated during the shift, nothing was triggered and LPT 1 just walked by Resident 1's room. LPT 1 stated at 2 am and 4 am, LPT 1 passed by Resident 1's room and LPT 1 did not see anything unusual. LPT 1 stated, during LPT 1's shift, LPT 1 did not see Resident 1 come outside of Resident 1's room. LPT 1 stated in the early morning (no recall of exact time) LPT 1 entered Resident 1's room and saw Resident 1 faced down on the floor between the bed and closet. LPT 1 stated LPT 1 tapped Resident 1 but Resident 1 was unresponsive. LPT 1 stated LPT 1 left Resident 1's room, walked to the door leading to the east unit and instructed CNA 4 to notify LVN 1 there was an emergency. LPT 1 stated he and LVN 1 went back to Resident 1's room and started performing CPR. During a review of the facility's CPR certifications, from the International CPR Institute (a company that offers first aid certification-training and CPR training), LPT 1's certificate indicated LPT 1 successfully completed a three-hour CPR course on [DATE] (LPT 1 was able to perform CPR). According to the American Red Cross Training Services, undated, for a person who was found unresponsive and not breathing CPR should be started and an AED (automated external defibrillator, portable electric device that automatically diagnose life threatening cardiac arrhythmias [irregular heartbeat]) should be used immediately. https://www.redcross.org/take-a-class/resources/learn-first-aid/unresponsive-and-breathing-person (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:48 pm with Housekeeper 1 (HK 1), HK 1 stated, today at around 6:30 am when HK 1 entered Resident 1's room, HK 1 saw Resident 1 on the floor next to Resident 1's bed and HK 1 told Resident 1 to get up and go to Resident 1's bed. HK 1 stated Resident 1's hands were blue, and HK 1 did not see Resident 1's face because it was tucked in Resident 1's chest. HK 1 stated Resident 1's bottom was facing up. HK 1 stated HK 1 told CNA 1 to check on Resident 1 because Resident 1 did not move [unresponsive] when HK 1 said anything [to Resident 1] and, something was wrong [with Resident 1]. HK 1 stated HK 1 did not touch Resident 1. During an interview on [DATE] at 1:56 pm, the DSD stated, on [DATE] at 6:25 am, the DSD went to the nurse's station to put up the [staff] assignment when CNA 1 called the DSD and told the DSD CNA 1 needed help. The DSD stated the DSD went to Resident 1's room, LPT 1 and LVN 1 were inside Resident 1's room and Resident 1 was [on the floor] kneeling toward Resident 1's head of the bed and was slumped over. The DSD stated Resident 1 was blue, not a normal color and Resident 1 had no pulse. The DSD stated LPT 1 and LVN 1 were standing next to Resident 1's body checking Resident 1, and the DSD instructed LPT 1 and LVN 1 to start CPR (to time recall of the time CPR was started) while the DSD ran outside Resident 1's room to get an oxygen [O2, colorless, odorless gas] tank, and instructed someone else (unidentified) to call 911. The DSD stated housekeepers were not CPR certified (not mandatory). During an interview on [DATE] at 2:17 pm, HK 2 stated HK 2 went inside Resident 1's room with HK 1 to clean Resident 1's restroom. HK 2 stated HK 1 started mopping Resident 1's room and HK 2 heard HK 1 talking to Resident 1 but Resident 1 was not responding. HK 2 stated HK 2 came out of the restroom to check the situation, saw Resident 1 in a baby position, and HK 2 only saw Resident 1's back. HK 2 stated HK 2 was not CPR trained-certified (unable to perform CPR). During a concurrent observation and interview on [DATE] at 2:20 pm with the DSD in the Administrator's (ADM) office desk, the DSD and surveyor watched the facility's surveillance video, dated [DATE] from 5:42 am to 7:08 am. The video showed the following sequence of events, on [DATE]: - At 6:28:00 am - HK 1 entered Resident 1's room. - At 6:28:35 am - CNA 1 entered Resident 1's room. - At 6:28:37 am - HK 1 was at Resident 1's doorframe talking to Housekeeping Supervisor (HKS). - At 6:29:02 am - CNA 1 exited Resident 1's room and walked towards the nurse's station. - At 6:29:03 am - HK 1 and HKS entered Resident 1's room. - At 6:29:33 am - CNA 1 entered Resident 1's room. - At 6:29:44 am -LPT 1 entered Resident 1's room. - At 6:30:09 am - CNA 1 exited Resident 1's room and walked down the hall. - At 6:30:20 am - HK 1 exited Resident 1's room. - At 6:30:25 - LPT 1 exited Resident 1's room. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- From 6:30:25 am to 6:30:59 am - LPT 1 was pacing the hallway, then opened the east unit's door and entered the unit (to notify LVN 1). - At 6:31:05 am - CNA 1 returned and entered Resident 1's room. - At 6:31:08 am - HKS exited Resident 1's room. - At 6:31:09 am - LPT 1 entered Resident 1's room. - At 6:31:21 am - LPT 1 exited Resident 1's room and walked toward the east unit. - At 6:31:31 am to 6:31:35 am - CNA 4 and LPT 1 walked out of the east unit, walked toward Resident 1's room, and entered Resident 1's room. - At 6:32:01 am - LVN 1 entered Resident 1's the room. CNA 4 exited Resident 1's room and walked toward to east unit. - At 6:33:00 am - CNA 5 entered Resident 1's room, exited at 6:33:22 am, entered at 6:33:30 am, exited at 6:33:40 am, and entered again at 6:33:28 am. - At 6:33:27 am - the DSD entered Resident 1's room. - At 6:33:40 am - the DSD exited Resident 1's room and ran toward the nurse's station. - At 6:34:03 am - CNA 1 exited Resident 1's room. - At 6:34:12 am - LVN 1 exited Resident 1's room and walked down the hallway. - At 6:34:25 am - LPT 1 entered Resident 1's room. - At 6:34:41 am - LPT 1 walked out of Resident 1's room and stood in the hallway. - At 6:35:01 am - LPT 1 and LVN 1 walked back into Resident 1's room. - At 6:35:19 am - the Infection Preventionist (IPN) entered Resident 1's room. - At 6:35:48 am - the IPN walked out of Resident 1's room. - At 6:36:25 am - the DSD entered Resident 1's room. - At 6:36:40 am - a staff member (unidentified) brought an 02 tank into Resident 1's room. - At 6:41:51 am - LVN 1 left Resident 1's room, walked toward CNA 1, and spoke with CNA 1 in the hallway. - At 6:42:15 am - LVN 1 returned and entered Resident 1's room. - At 6:42:28 am - the DSD and LVN 1 exited Resident 1's room. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At 6:43:54 am - the EMTs entered Resident 1's room. - At 6:44:04 am - Los Angeles Fire Department (LAFD) arrived and entered Resident 1's room. - At 7:08:46 am - the police department arrived. During this interview, the DSD stated when the DSD entered Resident 1's room at 6:33 am, the DSD instructed LPT 1 and LVN 1 to start CPR because neither one had started CPR (CNA 1 found Resident 1 unresponsive at 6:28 am). The DSD stated CPR should have been started by CNA 1 because CNA 1 was the first staff member at the scene. The DSD stated CPR was important because it was the first action that had to be done after checking for breathing and checking for a pulse. During an interview on [DATE] at 4:19 pm, CNA 1 stated on [DATE] around 6:30 am, HK 1 told CNA 1 to check Resident 1 and when CNA 1 entered Resident 1's room, CNA 1 saw Resident 1 on the floor. CNA 1 stated CNA 1 called Resident 1's name three times and Resident 1 did not respond, CNA 1 left Resident 1's room to inform LPT 1. CNA 1 stated CNA 1 did not perform CPR and did not touch Resident 1 because CNA 1 did not know if Resident 1 fell or had any injuries. CNA 1 stated this was the first time CNA 1 found an unresponsive resident. CNA 1 stated CNA's (in general) were trained to provide CPR and stated when finding an unresponsive resident: CNAs needed to provide CPR by checking a pulse, starting chest compressions, and needed to call a code 99 (activated when there is a medical emergency that requires a response from clinical staff). During a review of the facility's CPR certifications, the review indicated CNA 1 had Basic life Support (BLS, a level of medical care used for patients with life-threatening condition of cardiac arrest, performed until they can be given full medical care by advanced life support providers) certification from the American Heart Association, issue date [DATE], renew by ,d+[DATE]. During a follow-up interview on [DATE] at 4:38 pm with LPT 1, LPT 1 stated when LPT 1 entered Resident 1's room and saw Resident 1 on the floor, in a fetal position (curled up into a ball while laying on one side with legs and arms bent), the situation looked like an emergency and LPT 1 decided LPT 1 needed help from LVN 1 who was more experienced. LPT 1 stated LPT 1 left Resident 1's room to the east unit and told CNA 4, who was close to the door located between west and the east unit, to notify LVN 1 there was an emergency. LPT 1 stated if Resident 1 was not breathing and had no pulse, LPT 1 needed to check Resident 1's airway, breathing, circulation, check Resident 1's pulse, and start CPR immediately. LPT 1 stated CPR could save a life and it was the last defense for Resident 1 to get oxygen and pump [blood to] the heart. During an interview on [DATE] at 6:21 am, CNA 1 stated on [DATE], CNA 1 was assigned to care for Resident 1 (11 pm to 7 am). CNA 1 stated the last time CNA 1 saw Resident 1 was at the start of CNA 1's shift at 11 pm. During this time, Resident 1 was laying on Resident 1's bed, sleeping, and snoring. CNA 1 stated CNA 1 did not see Resident 1 after 11 pm. CNA 1 stated on [DATE] CNA 1 visually checked residents assigned to CNA 1 by sitting in the hallway located two rooms away from Resident 1's room but did not actually observe Resident 1 while the resident was inside the room. During a review of Resident 1's Follow Up Question Report (hourly location of Resident 1), dated [DATE], the log indicated CNA 1 documented Resident 1 was inside Resident 1's room from [DATE] at 9 pm to [DATE] at 6 am. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:25 am, with CNA 3, CNA 3 stated it was around 6:30 am when CNA 3 was returning from the laundry area and heard CNA 1 call for help. CNA 3 entered Resident 1's room and CNA 3 saw LPT 1, LVN 1, and Resident 1 lying on the floor. CNA 3 stated LVN 1 tapped Resident 1 and LVN 1 asked Resident 1, Are you okay? CNA 3 stated CNA 3 left the room when LPT 1 and LVN 1 started to turn Resident 1 on his back and CNA 3 saw the Director of Staff Development (DSD) on the DSD's way to Resident 1's room. During an interview with the Quality Assurance Nurse (QAN), on [DATE] at 11:30 am, the QAN was asked for Resident 1's POLST (a written medical order from a physician, nurse practitioner, or a physician assistant which specifies what a patient's lifesaving treatment wishes are). The QAN stated Resident 1 did not have a POLST and stated all residents residing at the facility were considered full codes unless there was an AD. The QAN stated Resident 1 did not have an AD. During a telephone interview on [DATE] at 1:30 pm, LVN 1 stated, on [DATE], LVN 1 went to Resident 1's room when LVN 1 was notified [by CNA 4] there was a medical emergency. LVN 1 stated LVN 1 saw Resident 1 on the floor with Resident 1's face down and told Resident 1 to get up but Resident 1 did not respond. LVN 1 stated Resident 1 had no pulse, was not breathing, and LVN 1 instructed the staff who were inside the room (unidentified) to call 911. LVN 1 stated Resident 1 was turned over and there was yellowish, clear liquid (approximately half a cup) with small spots of blood underneath Resident 1. LVN 1 stated the DSD came to Resident 1's room and instructed them (LVN 1 and LPT 1) to start CPR and Resident 1 was turned on Resident 1's back. LVN 1 stated LVN 1 initiated CPR but could not recall what time LVN 1 initiated CPR. LVN 1 stated it was around 6:30 am when CNA 4 informed him there was a medical emergency. During an interview on [DATE] at 2:49 pm, with the Director of Nursing (DON), the DON stated the facility staff needed to check responsiveness by calling the resident's name and if there was no response, staff needed to tap the resident, if there was still no response, staff needed to check for airway, breathing, and circulation. The DON stated if there was no pulse and no breathing, staff needed to call a code blue and start CPR to restart circulation and keep the heart beating. During a review of the facility's undated P&P titled, Advance Directive/Individual Health Care Instructions, the P&P indicated each resident will receive and the facility must provide the necessary care and services to attain or maintain the highest possible practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care by providing 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 directive. During a review of the facility's P&P titled, Emergency Response Policy and Procedure dated ,d+[DATE], the P&P indicated the facility will provide basic life support, including (Cardiopulmonary Resuscitation) CPR, to all residents requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advanced directives. The P&P indicated all residents of [the facility] are full code status unless otherwise indicated in an advanced directive that is given to the facility by the resident's responsible party.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40913 Based on interview and record review, the facility failed to ensure Certified Nursing Assistant 1 (CNA 1) and Licensed Vocational Nurse 1 (LPT 1) made hourly visual checks for five of five sampled residents (Resident 1, 2, 3, 4, and 6) during the night shift (11 pm to 7 am) as indicated in the facility's Policy and Procedures (P&P). This deficient practice had the potential to result in unmet needs, untimely assistance from staff, and distress to Residents 1, 2, 3, 4, and 6. Cross Reference F678 Findings: During a review of Resident 4's Admission Record (AR), the AR indicated the facility admitted Resident 4 on 12/1/2021 with diagnoses that included major depressive disorder (persistent feeling of sadness and loss of interest.) During a review of Resident 1's AR, the AR indicated the facility admitted Resident 1 on 4/15/2022 with diagnoses that included paranoid schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real), bipolar disorder (a serious mental illness that causes unusual shifts in mood, periods of depression and periods of elevated mood) unspecified, and obesity (a chronic health condition that involves excess body fat that may impair health). During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 11/25/2022 with diagnoses including schizoaffective disorder, major depressive disorder, and insomnia. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 6/8/2023 with diagnoses that included schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder) bipolar type, and insomnia (sleep disorder than can make it hard to fall asleep or stay asleep.) During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6 on 11/9/2023, with diagnoses that included schizoaffective disorder, insomnia and overweight. During an interview on 9/21/2024 at 6:21 am, CNA 1 stated, CNA 1 was assigned to care for Resident 1 during the night shift (11 pm to 7 am) on 9/19/2024. CNA 1 stated CNA 1 was assigned to monitor Resident 4 one to one (one staff to one resident) and was assigned to care for residents in rooms 30 to 37 (Residents 1, 2, 3, 4, and 6). CNA 1 stated on 9/20/2024 CNA 1 checked the residents assigned to CNA 1, by sitting in the hallway by Resident 4's room and observed when residents left their rooms (CNA 1 did not conduct visual checks in resident rooms). CNA 1 stated CNA 1 visually checked 1, 2, 3, 4, and 6, inside rooms, at the start of CNA 1's shift (11 pm) and did not conduct visual checks after that. CNA 1 stated Resident 1 was laying on Resident 1's bed, sleeping, and snoring. (continued on next page)

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	05A134	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 9/21/2024 at 6:52 am with CNA 1, CNA 1 stated at the start CNA 1's shift on 9/19/2024, CNA 1 visually checked the residents and opened the curtains to check if the residents were in their bed sleeping. CNA 1 stated the facility process was for CNAs (in general) to use a clicker (security wand, scanned inside resident room and documents visual resident monitoring) but that night (9/19/2024 to 9/20/2024) there was no clicker available due to the clicker being fixed. CNA 1 stated the clicker was used to show staff entered resident rooms to visually check the residents. CNA 1 stated because CNA 1 was monitoring Resident 4 one to one, CNA 1 had to document Resident 4's location every 15 minutes. CNA 1 stated CNA 1 stayed in the hallway close to Resident 4's room and from where CNA 1 was sitting, CNA 1 could not see inside Residents 1, 2, 3, 4, or 6's rooms. During an interview on 9/21/2024 at 7:02 am, with Licensed Psychiatric Technician 1 (LPT 1), LPT 1 stated LPT 1 started his shift at 11 pm. LPT 1 stated LTP 1 was finished with clerical work at 11:45 pm and visually checked on 3 residents (unidentified) who were considered critical because they had recent incidents such as suicide ideation. LPT 1 stated LPT 1 did not visually check Resident 1 because Resident 1 was not identified as critical and stated the CNA's (in general) checked the residents who were in the CNA's assigned zones. LPT 1 stated the assignment on the unit was already made by the Director of Staff Development and on 9/19/2024 during the 11pm to 7am shift, there were four certified nursing assistants and two were assigned to do one to one monitoring for two residents. LPT 1 stated LPT 1 did not know CNAs used a clicker and LPT 1 was a new staff and was still learning the facility's process. During an interview on 9/21/24 at 11:46 am, LVN 3 stated the CNA assignments were completed by the DSD and there were usually 3 CNAs assigned during the night shift. LVN 3 stated two CNAs monitored every shift, one did one to one monitoring and document the resident's location every 15 minutes. LVN 3 stated, there routine monitoring conducted hourly, done by the CNAs who were not doing one to one monitoring. During a review of the night shift Nursing Staffing Assignment and Sign-In Sheet dated 9/19/2024, the staffing assignment indicated there were four CNA's working: one CNA did one to one monitoring and 3 CNAs were assigned zones. The staffing assignment indicated CNA 1 was assigned to 13 rooms. The staffing assignment indicated Resident 4 was on one-to-one monitoring. During an interview on 9/21/2024 at 2:49 pm, the Director of Nursing (DON) stated the staff that saw (visual checks) the resident would document on that resident. The DON stated, hourly monitoring indicated the location of the resident and details including whether in bed, dining area, or in the hallway. The DON stated it was facility practice for the staff to conduct rounds (check on residents) and the DON suggested the use of a flashlight. The DON stated, the staff needed to visually check [look at] the resident's location. During a review of Resident 1's Hourly Location on 9/20/2024, the Hourly Location indicated CNA 1 documented Resident 1 was inside Resident 1's room from 9/19/2024 at 11 pm to 9/20/2024 at 06 am. During a review of the facility's P&P titled, Policy for Hourly Monitoring of Residents dated 5/2024, indicated it is the policy of the facility to provide an atmosphere that is safe and secure for all residents and staff. The P&P indicated the CNA will observe the location of each resident assigned in their section, this monitoring allows the staff to account for each resident and ensures that each resident is free from distress. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Zoning Policy dated 12/3/2020, the P&P indicated the facility will provide an atmosphere that is safe and secure for the clients and staff. CNAs are scheduled to a specific unit, the CNA will observe the location of each resident assigned in their section and mark the location in their hourly sheet. This monitoring allows the staff to account for each person and makes sure that each resident is free from distress. The P&P indicated every shift will conduct hourly in-room inspection in teams of two, one staff at doorway of room to supervise hall and witness co-workers' entrance to room and one staff to enter room to conduct a visual inspection of room. During a review of the facility's P&P titled Security Wand dated 2021, the P&P indicated the staff will check each resident room every 15 minutes by tapping the security wand on the black disk located on the wall, over the intercom speaker. This method of monitoring will allow for a safer environment for the residents. This new system will take the place of hourly room checks as the rooms are being checked every 15 minutes. Hourly Resident location remains in place with no changes. During a review of the facility's P&P titled, Policy for Hourly Monitoring of Residents, dated 5/2024, the P&P indicated the facility was to provide an atmosphere that was safe and secure for all residents and staff. The P&P indicated each CNA was assigned to a zone in the unit and the CNA would observe the location of each resident assigned in their section, each hour, and document the location of the resident.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on interview and record review, the facility failed to ensure Certified Nurse Assistant 1 (CNA 1) and Licensed Psychiatric Technician 1 (LPT 1) demonstrated competency during a medical emergency for one of one sampled resident (Resident 1) who was found on the floor unresponsive on [DATE]. Additionally, the facility failed to provide 37 of 74 CPR certificates for direct care staff. This deficient practice had the potential to result in a delay in treatment and delivery of cardiopulmonary resuscitation (CPR - emergency lifesaving procedure, consisting of a combination of chest compressions, mouth- to-mouth, or mechanical breathing [using a device to help someone breaths], performed when the heart stops beating or beats ineffectively and/or to restore breathing) to Resident 1 and had the potential to affect all other residents residing at the facility. Cross Reference F678 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on [DATE] with diagnoses that included paranoid schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real), bipolar disorder (a serious mental illness that causes unusual shifts in mood, periods of depression and periods of elevated mood) unspecified, and obesity (a chronic health condition that involves excess body fat that may impair health). During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated [DATE], the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], the MDS indicated Resident 1's cognition (ability to understand and process information) was intact, had clear speech, and had the ability to understand and be understood (ability to express ideas and wants) by others. The MDS indicated Resident 1 did not have any impairments (an injury, illness, or a condition where part of your body or brain does not work as it normally should) on the upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on [DATE] at 4:38 pm with LPT 1. LPT 1 stated when LPT 1 entered Resident 1's room and saw Resident 1 on the floor, in a fetal position, the situation looked like an emergency and LPT 1 decided LPT 1 needed help from LVN 1 who was more experienced (LVN 1). LPT 1 stated LPT 1 left Resident 1's room to the east unit and told CNA 4, who was close to the door located between west and the east unit, to notify LVN 1 there was an emergency. LPT 1 touched Resident 1's back, Resident 1 did not respond and LPT 1 realized something bad happened. LPT 1 stated LVN 1 came and looked at Resident 1 and both LPT 1 and LVN 1 turned Resident 1 over to position the resident to start CPR. LPT 1 stated if Resident 1 was not breathing and had no pulse, LPT 1 needed to check Resident 1's airway, breathing, circulation, check Resident 1's pulse, and start CPR immediately. LPT 1 stated CPR could save a life and it was the last defense for Resident 1 to get oxygen and pump [blood to] the heart. During an interview on [DATE] at 6:21 am, CNA 1 stated Housekeeper 1 (HK 1) told CNA 1 to check on Resident 1 because Resident 1 was on the floor. CNA 1 stated CNA 1 called Resident 1's name three times but Resident 1 did not move or respond. CNA 1 stated CNA 1 thought Resident 1 fell and CNA 1 left the room to notify LPT 1 because CNA's were not supposed to move the resident who fell until the licensed nurse had already checked the resident. During an interview on [DATE] at 7:02 am, LPT 1 stated CNA 1 called Code 99 (activated when there is a medical emergency that requires a response from clinical staff) which meant there was an emergency. LPT 1 stated LPT 1 went to Resident 1's room to check on the resident and Resident 1 on the floor and bent over with the right hand curled inward. LPT 1 stated LPT 1 observed Resident 1 for a few seconds and LPT 1 thought Resident 1 could have had an emergency or a behavior and usually with emergencies LPT 1 would consult the more experienced licensed nurse so he ran towards the other unit which was just across Resident 1's room and told CNA 4 to notify LVN 1 there was an emergency and needed LVN 1's help. LPT 1 stated LPT 1 went back to the room and Resident 1 was still bent over so LPT 1 talked to Resident 1 and could not get a response from the resident. LPT 1 touched Resident 1's back, Resident 1 did not respond and LPT 1 realized something bad happened. LVN 1 came and looked at Resident 1 then both of them turned Resident 1 over to position the resident so they could administer CPR. During a review of CPR certifications for all direct care staff on [DATE] at 10:30 am with the Administrator (ADM). The ADM stated there were 74 direct care staff members. There were only 37 CPR certificates available for review. The ADM stated the Director of Staff Development (DSD) was unavailable but had informed the ADM that the DSD needed to print the CPR certificates because the staff would just e-mail the certificates to the DSD. The ADM did not provide any other proof that CPR certifications for all direct care staff members were current. During a review of CNA 1's Skills Competency Review on [DATE] at 2:40 pm, the review was dated [DATE]. During a concurrent interview, the DON stated the Director of Staff Development (DSD) was responsible for the CNA Skills Competency Review and could not find evidence CNA 1 had a current evaluation. During an interview on [DATE] at 2:49 pm, with the Director of Nursing (DON), the DON stated the facility staff needed to check responsiveness by calling the resident's name and if there was no response, staff needed to tap the resident, if there was still no response, staff needed to check for airway, breathing, and circulation. The DON stated if there was no pulse and no breathing, staff needed to call a code blue and start CPR to restart circulation and keep the heart beating. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure titled Nursing Staff Competency Skills Check Evaluation, dated ,d+[DATE], the P&P indicated all nursing staff will have competency skills evaluations completed upon orientation and then annually. The policy indicated competency skills evaluations may be done as needed to monitor for safety and best practices at the discretion of the Staff Developer and/or Director of Nursing. During a review of the facility's Facility assessment dated [DATE], the Facility Assessment indicated staff received ongoing in-service, competency-based training, and education to provide an optimum level of care and support for the resident population based on the types of diseases, conditions, physical and behavioral health needs, cognitive disability, overall acuity, and other pertinent facts that are present within the population.