STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365277	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradford Place Care Center	1302 Millville Avenue Hamilton, OH 45013

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, review of the emergency medical services (EMS) run report, review of the hospital record review, staff interviews and policy review, the facility failed to ensure a resident was adequately prepared for a transfer by ensuring EMS and the hospital was provided with the resident's code status and other pertinent information. This affected one (#100) of three residents reviewed for hospitalization . Facility census was 70. Findings include: Review of the medical record of Resident #100 revealed an admitted [DATE]. The resident transferred to the hospital on 02/23/24 and did not return to the facility. Diagnoses included spinal stenosis, type 2 diabetes mellitus, Alzheimer disease, dementia with mood disturbance, major depressive disorder, anxiety disorder, hyperlipidemia, and hypertension. Review of Resident #100's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of the medical record revealed a Change of Condition Evaluation was initiated on 02/23/24 but the form/evaluation was not completed. Review of physician orders revealed an order dated 10/20/21 (discontinued 02/26/24) for the resident to be a Do Not Resuscitate Comfort Care-Arrest (DNRCC-Arrest). Review of the care plan dated 01/25/22 revealed the resident had an advanced directive of a DNRCC-Arrest. Interventions included to follow the facility protocol for identification of code status. Review of a progress note dated 02/23/24 at 5:18 P.M. revealed Resident #100 was found in her room unresponsive to verbal and physical stimuli. Call was placed to nine-one-one (911) and assistance was received from other staff nurses. Vital signs were obtained-temperature was 98.4 degrees Fahrenheit, pulse was 86 beats per minute, respirations were 14 breaths per minute, blood pressure was 180/110, oxygen saturations were 97% on room air. The squad arrived and Resident #100 was transported to the hospital. Family and the Director of Nursing (DON) were notified. Report was called to the hospital, along with the resident's code status, DNRCC-Arrest. (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

Printed: 08/01/2024
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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMS run report, dated 02/23/24, revealed facility staff stated Resident #100 had a DNR but had no further information or documentation was provided. There was no DNR presented to EMS and the only medical history obtained from the facility was diabetes. Review of a hospital physician progress note dated 02/23/24 at 7:10 P.M. revealed Resident #100 arrived without access to her goals of care, however, after discussion with the resident's spouse, aggressive measures were not desired. Once the resident was fully registered, there was a pre-existing DNRCC-Arrest order in place. The family wished to discontinue invasive management and continue with comfort care measures as soon as possible. Review of hospital consult notes dated 02/24/24 at 8:50 A.M. revealed there was no paperwork for Resident #100 by EMS and no family was around so the resident was intubated due to being unable to provide a tactical airway. The resident was found to have a DNRCC-Arrest code status prior to admission and once the resident's family was ready, terminal extubation and withdrawal of life support was planned. Condition was noted to be terminal and death was imminent. Review of hospital history and physical, dated 02/24/24 revealed Resident #100 was admitted to the hospital 02/23/24 at 5:56 P.M. Resident #100 presented after being found unresponsive and brought to the emergency room department without paperwork showing her DNRCC-Arrest and thus was intubated. Resident #100 was found to have a large pontine hemorrhage with extension into the fourth ventricle. Resident #100 was admitted to the intensive care unit (ICU) and ventilation was continued until family was able to be contacted and the appropriate paperwork obtained. Interview on 05/15/24 at 1:01 P.M. with Licensed Practical Nurse (LPN) #410 revealed she was aware of an incident involving Resident #100 being sent to the hospital without appropriate DNRCC-Arrest paperwork. LPN #410 stated she was not the nurse for Resident #100 the day of the hospitalization , but she was helping the nurse who was responsible for the resident and the printer was not working and the resident was sent to the hospital without the DNRCC-Arrest paperwork. Interview on 05/16/24 at 10:05 A.M. with LPN #310 stated she was not present in the building at the time of the incident involving Resident #100's hospitalization , however she was told the staff could not get paperwork including the residents DNRCC-Arrest form to print. LPN #310 stated Resident #100 was sent to the hospital emergently and staff were unable to send a face sheet and code status information with EMS because the printer was not working. Review of the facility policy titled, Discharging the Resident, dated 12/2016, revealed, if a resident is transferred to the hospital, the facility would ensure a transfer summary is completed. This deficiency represents non-compliance investigated under Complaint Number OH00153365.