STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365316	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Square Nursing and Rehabilitation	1211 W Market St Akron, OH 44313

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 - 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** 35768 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on closed record review, review of the facility's investigation, review of facility timeline, review of emergency medical services (EMS) run report, staff interview, and policy review, the facility failed to provide basic life support (BLS), including Cardiopulmonary resuscitation (CPR) to Resident #61 per the resident's advance directive, when the resident was found unresponsive on the toilet. This resulted in Immediate Jeopardy and serious life-threatening harm and the subsequent of death of Resident #61 beginning on [DATE] when Certified Nursing Assistant (CNA) staff alerted Licensed Practical Nurse (LPN) #341 who assessed Resident #61 and found the resident to be unresponsive. Instead of providing immediate care, LPN #341 contacted LPN #346 who was working on another floor for guidance. LPN #346 then contacted Unit Manager #354, who was at home asking for guidance related to finding Resident #61's advanced directives. LPN #341 had a difficult time finding the resident's advanced directives as LPN #341 denied having immediate access to the computer and the resident's hard medical chart. EMS was contacted and arrived on-site at which time Resident #61 was pronounced deceased ; EMS staff indicated it was too late for CPR. This affected one resident (#61) of four residents reviewed for death in the facility. On [DATE] at 10:33 A.M. the Administrator, Regional Nurse, Regional Administrator and [NAME] President of Operations were notified Immediate Jeopardy began on [DATE] at approximately 11:30 P.M. when upon answering Resident #61's call light, CNA #329 and CNA #368 observed Resident #61 in the bathroom sitting on the toilet in distress. The CNA staff alerted LPN #341 who assessed Resident #61 and found the resident to be unresponsive. Instead of providing immediate care, LPN #341 contacted LPN #346 who was working on another floor for guidance. LPN #346 then contacted Unit Manager #354, who was at home asking for guidance related to finding Resident #61's advanced directives. LPN #341 had a difficult time finding the resident's advanced directives as LPN #341 denied having immediate access to the computer and the resident's hard medical chart. EMS was contacted and arrived on-site at which time the resident was pronounced deceased as EMS staff indicated it was too late for CPR. The staff had left Resident #61 slumped over on the toilet until EMS arrived (at approximately 11:45 P.M. per the facility timeline). The Immediate Jeopardy was removed on [DATE] and subsequently corrected on [DATE] when the facility implemented the following corrective actions. (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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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] between 12:00 A.M.-4:00 P.M., the Director of Nursing (DON) provided education on Advance Directives, location of advanced directives, change of condition, and immediate response of CPR. The education was provided to all staff that were in-house and those not in-house received training via phone. Training was verified by review of sign in sheets. On [DATE] the DON and Administrator interviewed and/or collected statements from all staff working at the time of the incident involving Resident #61. All staff involved were on site for these interviews. On [DATE] at 1:35 P.M., a whole house audit of all residents was completed by the Regional Director of Clinical Services (RDCS) verifying code status, care plans and signed Do Not Resuscitate (DNR) forms. No concerns were identified. On [DATE] at 2:30 P.M. the Human Resource Director reviewed all nursing staff files to verify cardiopulmonary resuscitation (CPR) certifications were valid. All certifications were valid and up to date. On [DATE] at 2:35 P.M. the RDCS verified all laptops on the units were accounted for. Three laptops and two desktops were available. (One desktop at first and third floor nurse stations and three laptops on three of the six medication carts [one on each unit. One nurse passes medications for the entire unit. The nurse takes the laptop from one medication cart to the other]). This was verified via surveyor observation. On [DATE] at 4:30 P.M. the DON audited crash carts and all equipment was in place. On [DATE] at 7:30 P.M., an ADHOC Quality Assurance and Performance Improvement (QAPI) meeting was completed to discuss Advance Directives for all residents. The outcome of the meeting was the development of education pertaining to Advance Directives, location of advanced directives, change in condition, immediate response of CPR. All interdisciplinary team members including the Administrator, DON, Unit Manager, Maintenance Director, Activities Director, Dietary Director, Business Office Manager and Admission Director were in attendance with the Medical Director in attendance via phone. On [DATE] at 11:30 A.M. a second ADHOC QAPI meeting was held. Discussion included but was not limited to the different code status levels and how staff were expected to respond and implementation of the corrective action plan and if any adjustments were required. On [DATE] at 11:45 A.M., staff received education on advanced directives, location of the advanced directives, immediate response of CPR and change in condition by The RDCS and DON. Any staff who were unable to attend in-house were trained via telephone. Completion of this training was verified via review of staff sign-in sheets and random interviews with staff. Beginning [DATE] at 3:10 P.M. the facility implemented a plan for the DON/Designee to conduct Code Blue drills and location of advance directives on alternating shifts three times a week for four weeks then weekly thereafter. Audit completion was reviewed and confirmed via review of auditing documentation sheets beginning on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning [DATE] at 3:10 P.M. the facility implemented a plan for the Administrator/Designee to audit all deaths that occurred to ensure resident's advanced directives were honored per preference five times a week for four weeks, then weekly thereafter. Auditing was confirmed via review of auditing documentation sheets (there were three deaths reviewed (one occurred on [DATE], one on [DATE] and one on [DATE]); two residents had advance directives for a DNRCCA status, and one resident was a DNR-CC). Beginning on [DATE] at 3:10 P.M. the facility implemented a plan for the DON/Designee to conduct audits to ensure that residents' change in conditions were addressed five times a week for four weeks, then weekly thereafter. Audit completion was reviewed and confirmed via review of auditing documentation sheets beginning on [DATE]. Beginning on [DATE] at 3:10 P.M. the facility implemented a plan for the DON/Designee to conduct audits to ensure each unit had a laptop for nursing access five times a week for four weeks. Audit completion was reviewed and confirmed via review of auditing documentation sheets beginning on [DATE]. Findings include: Review of Resident #61's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including cognitive social or emotional deficit following an unspecified cerebrovascular disease, mild vascular dementia, chronic obstructive pulmonary disease, atrial fibrillation (irregular heart rhythm), congestive heart failure, polyosteoarthritis, and old myocardial infarction (MI). Review of the physician's orders revealed an advance directive order dated [DATE] indicating the resident was a full code status. Review of Resident #61's care plan with a creation date of [DATE] revealed Resident #61 desired to be a full code (advance directives). A full code status indicates a resident wants all life-saving measures used in a medical emergency. Review of the admission Minimum Data Set assessment with an assessment reference date of [DATE] revealed Resident #61 had range of motion impairment to upper and lower extremities on one side and required substantial/maximal (staff) assistance with toilet transfers. Resident #61 utilized a manual wheelchair for mobility. Review of an untimed progress note dated [DATE] revealed Resident [Resident #61] expired [DATE] at 00:00. R [resident] assessed by nurse and other nurse in building. Contacted MD, DON, sister. Contacted summit county corner (sic) spoke with (name provided) at 00:16 gave permission to release r [resident] to funeral home. Contacted (name of funeral home) spoke with (name provided). Funeral home picked r [resident] up at 01:27 exited on elevator gave copy of face sheet & medication list. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an EMS run report revealed a public safety answering point of [DATE] at 11:41 P.M. EMS was at patient at 11:48 P.M. The incident/patient disposition indicated DOA (dead on arrival)-no resuscitation attempted. Primary impression indicated obvious death. The narrative indicated M9 dispatched to (address of facility) Skilled Nursing Facility. 67 yom (year old male) reports of not breathing. Upon arrival facility staff in room and state we think he's deceased . Pt (patient) has rigor set in and pooling noted. Pt is cold to touch, obvious signs of death and 3 lead ecg (electrocardiogram) shows asystole (no heartbeat). Pronouncement and after death care left to facility. Facility requested medic crew assistance moving body, declined by crew due to nature of pt and possible medical examiner investigation. Detailed findings indicated skin cold, mottled, lividity. Review of the timeline (and corresponding staff statements) provided by the facility revealed the following information: CNA #368 reported on [DATE] about 11:30 P.M. Resident #61's bathroom call light was on when she responded she saw Resident #61 appeared to be slumped over on his toilet and appeared to be talking with CNA #329. CNA #368 could hear CNA #329 talking but couldn't tell if Resident #61 was talking. CNA #368 reported she immediately called for the nurse. CNA #329 reported on [DATE] about 11:30 P.M. Resident #61 was banging on his wall and when he entered the room Resident #61 was saying something about getting off the toilet to his wheelchair; he appeared to be in distress, and CNA #368 and CNA #329 went and got the nurse. LPN #341 reported on [DATE] at 11:35 A.M. she was standing at the nurse's station when CNAs (unnamed) near Room (number provided) called her to the room. LPN #341 reported Resident #61 was slumped over, face was pale, and hands and feet were purplish. LPN #341 assessed Resident #61 and was unable to feel a pulse. LPN #341 then went and got the vitals cart and again no vital signs were detected. At 11:39 P.M. (verified with DON's phone) LPN #341 called and let DON know Resident #61 was in distress and was instructed to call 911. At 11:40 P.M. LPN #341 reported calling 911 while other nurse on duty (not identified) also assessed Resident #61 at this time and couldn't get a pulse. LPN #341 immediately went to get Resident #61's chart but couldn't find his chart, so she checked Point Click Care (PCC) for code status. When going to get the CPR equipment EMS arrived. At 11:45 P.M. EMS was on site in resident's room; hooked Resident #61 up to monitor and reported Resident #61 was deceased . EMS refused to assist with moving the resident. Between 11:50 P.M. and 12:00 A.M. staff assisted in getting Resident #61 from toilet to wheelchair to bed. On [DATE] at 12:00 A.M. the nurse (not identified) contacted the MD, DON and resident's sister to notify that Resident #61 had expired. Interview with LPN #354 (nurse supervisor) on [DATE] at 4:03 P.M. revealed she received a call from LPN #346 (on [DATE]) around 12:00 A.M. asking what she should do as staff didn't know what to do regarding Resident #61 being on the toilet unresponsive. The supervisor revealed LPN #346 was instructed to call EMS, get the crash cart and look for code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #346 on [DATE] at 11:39 A.M. revealed she was working on [DATE] on another unit downstairs when LPN #341 called for help. LPN #346 went to the third floor and assessed Resident #61 and asked staff for the resident's code status. However, they couldn't find Resident #61's chart. LPN #346 stated she checked for pulses, and the resident was mottled. When EMS arrived, they declared Resident #61 dead. LPN #341 said she called the DON at that point, and she called Resident #61's sister. There was a nurse and two CNAs working on the third floor at the time and no code was called. Interview with CNA #368 on [DATE] at 1:51 P.M. revealed on [DATE] she was working on the third floor and went into Resident #61's room. Resident #61 was on the toilet, and she saw his hands were yellowish, CNA #329 asked Resident #61 if he was okay. CNA #329 said Resident #61 mumbled. LPN #341 was in and out of room several times. CNA #368 reported Resident #61's pulse was faint at first, but a couple minutes later the pulse was gone. CNA #368 indicated Resident #61 was not taken off the toilet and CPR was not completed. EMS said Resident #61 was DOA and left the facility. CNA #368 reported the audible signal to the call light system was disconnected that night; the cord from the annunciator panel at the desk had been disconnected. CNA #368 revealed when she arrived for her night shift she saw Resident #61's call light was on but there was no sound. CNA #368 said she checked the call light panel and saw Resident #61's call light had been on for more than 30 minutes. Interview with LPN #341 on [DATE] at 1:56 P.M. revealed CNAs were outside of Resident #61's room when they heard a sound on the wall and they entered the room. When LPN #341 entered the room Resident #61 was on the toilet. LPN #341 checked for a pulse and found no signs of a pulse. Resident #61 was slumped forward, his hands were purplish, face was pale, and his skin was warm. LPN #341 said she called 911 and asked the aides for his chart. A second nurse came up to help. LPN #341 had looked at the computer and Resident #61 was a full code. EMS arrived and declared Resident #61 dead. LPN #341 reported they were not able to complete CPR because they could not get the resident off the toilet. A follow-up interview with LPN #341 on [DATE] at 8:09 A.M. revealed at the time of the incident, she went to the computer to find Resident #61's code status. LPN #341 stated she was not sure who found the chart, but it was nowhere to be found on the third floor. LPN #341 confirmed Resident #61 did not have a pulse when she first assessed him. Interview with LPN #307 (unit manager) on [DATE] at 8:33 A.M. revealed a resident's code status could be found in the electronic medical record and the nurses always had access to a computer. Review of the facility's Emergency Procedure-Cardiopulmonary Resuscitation policy and procedure dated [DATE] revealed if an individual was found unresponsive and not breathing normally, a licensed staff member who was certified in CPR/BLS was to initiate CPR unless it was known that a DNR order that specially prohibited CPR and/or external defibrillation existed for that individual or if there were obvious signs of irreversible death (e.g., rigor mortis). If the resident's DNR status was unclear, CPR was to be initiated until it was determined that there was a DNR or a physician's order not to administer CPR. This deficiency represents non-compliance investigated under Complaint Number OH00165334.