

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365605	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Milcrest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 730 Milcrest Drive Marysville, OH 43040	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on review of the facility's Self-Reported Incident (SRI) and investigation, review of the facility's video surveillance, closed medical record review, review of the hospital records, staff interviews, and review of the facility policy, the facility failed to ensure a resident was free from neglect when the Director of Nursing (DON) and License Practical Nurse (LPN) #21 failed to adequately assess, monitor, and timely notify the physician of the resident's condition in accordance with professional standards of practice. This resulted in Immediate Jeopardy, serious life-threatening harm, and ultimate death when on [DATE] at 5:13 P.M., Resident #15 had a change in condition and at 5:54 P.M., State tested Nursing Aides (STNA) #34 and #58 found Resident #15 grabbing at his chest, unresponsive to verbal commands, and in respiratory distress and alerted the DON to the resident's change of condition. There were no ongoing assessments during the evening shift and no notification to the physician for the need to alter treatments and/or send the resident out for evaluation, treatment or care. On [DATE] at 11:55 P.M., STNA #34 found the resident to be unresponsive and notified LPN #21 to come to the room and LPN #21 stated Resident #15 was dead. LPN #21 did not immediately initiate Cardiopulmonary Resuscitation (CPR) or contact the physician. There was a nine-minute delay in CPR being started and ten-minute delay to notify Emergency Medical Services (EMS). EMS responded and transported Resident #15 to the emergency room where he expired on [DATE] at 12:50 A.M. This affected one (Resident #15) of three (#15, #41, and #47) residents reviewed for neglect. The facility census was 47 residents. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365605	Facility ID: 365605 If continuation sheet Page 1 of 17

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:27 P.M., the [NAME] President of Operations #140 and Clinical Director #143 were notified Immediate Jeopardy began on [DATE] at 5:54 P.M. when Resident #15 was found by STNAs #34 and #58, grabbing at his chest, unresponsive to verbal commands and in respiratory distress. STNA #58 alerted the DON who was in the hall. STNA #58 and the DON entered the resident's room and proceeded to attempt to verbally stimulate Resident #15 to breathe. The DON attempted to obtain a blood pressure at 6:10 P.M. and was unable to get a blood pressure; however, oxygen saturation and heart rate were taken which was reported to be normal. At 6:00 P.M., STNA #58 ran back into Resident #15's room and told the DON that the resident was a full code. There was no notification to the physician, or activation of emergency services at that time. It was not until approximately 7:34 P.M. that a nurse (LPN #21/night shift) entered Resident #15's room and exited shortly afterwards after a brief discussion with the family about the resident being a full code and not on hospice. The next time LPN #21 entered the resident's room was at 11:55 P.M. after STNA #34 entered the room and noticed the resident had expired. At 11:56 P.M., LPN #21 left Resident #15's room, sat down at the nurse's station, and did not make any telephone calls immediately to notify the physician and/or EMS. On [DATE] at 12:00 A.M., LPN #21 notified the DON that Resident #15 was dead, and she did not complete CPR and refused to initiate the CPR. At 12:03 A.M., the DON had LPN #56 initiate CPR on Resident #15. At 12:04 A.M., LPN #21 notified EMS. The physician was never notified. EMS responded and transported Resident #15 to the emergency room where he expired on [DATE] at 12:50 A.M. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE], Staffing Agency #500 was made aware of the neglect allegations involving LPN #21. LPN #21 was placed on the Do Not Return list. On [DATE], the Administrator and [NAME] President of Operations #140 suspended the DON. On [DATE], the DON was terminated as an employee from the facility. On [DATE], all 56 employees at the facility were educated on the facility's abuse policy including identification of neglect and reporting an allegation of neglect. On [DATE] at 10:33 A.M., the facility initiated an investigation. On [DATE], an Ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held to determine the root cause of the Immediate Jeopardy. On [DATE], LPN #93 and Registered Nurse (RN) #177 educated all 16 licensed nursing staff regarding identification of change in condition, the components of a comprehensive assessment, monitoring of the change in condition as well as timely notification of the physician according to professional standards of practice. In addition, all staff were educated regarding the prevention, identification and reporting of abuse to include neglect according to facility policy. On [DATE], 50 residents were interviewed regarding abuse. There were no concerns about any allegations of abuse/neglect made known as a result of the interviews. On [DATE], the facility submitted the initial SRI. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the Local Police and the Ohio Board of Nursing were made aware of the neglect allegation involving the DON. On [DATE], Quality Assurance Director (QAD) #180 completed an audit of nurse's progress notes to identify any resident that experienced a change in condition without being appropriately assessed, monitored and reported timely to the physician. A comprehensive assessment was performed for any resident identified as experiencing a change in condition not appropriately assessed, monitored and timely report made to the physician. The audit was conducted for the timeframe of [DATE] to [DATE]. On [DATE], QAD #180 completed an audit on 50 residents' progress notes to identify any documentation indicating an incident of abuse including neglect, as well as any other category of reportable incident according to the Centers for Medicare and Medicaid Services (CMS) regulation, had occurred. No documentation was identified indicating a reportable incident occurred. On [DATE], Clinical Director #143 educated the facility's 13 Directors and Supervisors regarding the investigation and reporting requirements according to CMS regulation for all reportable events including neglect. Beginning on [DATE], the facility will complete questionnaires to evaluate licensed nursing staffs' understanding of the components of a comprehensive assessment, monitoring of the change in condition, and timely notification of the physician according to professional standards of practice as well as audits also in the form of questionnaires consisting of staff understanding of abuse identification and reporting specifically neglect. This will be conducted six times per week each for four weeks to include all shifts. Beginning on [DATE], the facility will complete audits in the form of questionnaires which will be conducted by the facility Directors and Supervisors to evaluate understanding of incident investigation and reporting requirements. The audits will be conducted six times per week for four weeks. Beginning on [DATE], the facility will complete audits consisting of review of nurse's progress notes to determine completion of a comprehensive assessment, monitoring of a change in condition and timely notification of the physician according to professional standards of practice. The audits will be performed three times a week for four weeks. Beginning on [DATE], the facility will submit their audit findings to the QAPI Committee weekly for recommendations. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the closed medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included atrial fibrillation, mesothelioma (an aggressive and rare form of cancer that usually occurs in the thin layer of tissue that lines the lungs or the abdomen), and respiratory failure with hypoxia. Resident #15 died on [DATE] at 12:50 A.M. at the emergency room . Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was cognitively intact and required substantial/maximal assistance from staff for toileting. Review of the physician orders for Resident #15 revealed an order dated [DATE] for the resident to be a full code. Review of Resident #15's medical record revealed there was no documentation of a blood pressure reading or the inability to obtain blood pressure. There was no documentation that the physician was notified of Resident #15's change in condition. There was no documentation of a respiratory assessment, neurological assessment, pain assessment, or cardiac assessment completed after the DON was alerted by STNAs #34 and #58 of Resident #15's change of condition at 6:00 P.M. Review of the progress note dated [DATE] at 7:00 P.M. revealed LPN #21 documented Resident #15 was in respiratory distress when this nurse arrived to report for shift. The DON was in the room with the resident. The DON reported all vitals within normal limits and does not see any need to send the resident out to the hospital when the day shift nurse recommended to send him to the hospital. There was no documentation of vital signs, notification of physician, no documentation of respiratory assessment, neurological assessment, pain assessment, or cardiac assessment completed by LPN #21. The progress note dated [DATE] at 11:40 P.M. (the facility's video surveillance shows actual time was 11:55 P.M.) revealed LPN #21 was notified by STNA #34 to assess Resident #15. Resident #15 was found in bed and unresponsive. There was no documentation that CPR was initiated, or the physician was notified. Review of Resident #15's hospital records revealed on [DATE] at 12:50 A.M., Resident #15 was pronounced dead. Review of the facility's SRI revealed the facility concluded the allegation of neglect was substantiated on [DATE]. The facility's review of video and video audio on [DATE] from 5:00 P.M. to midnight showed the DON failed to assess, monitor, and timely notify the physician of Resident #15's change in condition. The DON stated, He is transitioning and discusses the inability to obtain blood pressure and he was shaking. The facility substantiated the allegation of neglect and concluded the DON did not adequately assess, monitor, and timely notify the physician of Resident #15's change of condition which led to his death. Interview with STNA #34 on [DATE] at 10:30 A.M. revealed during the change of shift at approximately 6:00 P.M. on [DATE], she and STNA #58 found Resident #15 in severe distress, eyes wide open, grabbing at his chest, and he looked like he was having trouble breathing. They both went to the hall to get help and found the DON and she went into Resident #15's room. STNA #34 stated she found Resident #15 unresponsive and cold during the 11:00 P.M. to 11:30 P.M. rounds (the facility's video surveillance shows actual time was 11:54 P.M.) and alerted LPN #21 of Resident #15's condition. STNA #34 was unable to remember the last time she provided care to Resident #15 prior to finding Resident #15 unresponsive. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Nurse Practitioner (NP) #75 on [DATE] at 1:30 P.M. confirmed there was no communication from the facility regarding Resident #15's change of condition at 6:00 P.M. or when staff found him unresponsive at 11:55 P.M. NP #75 confirmed any change of condition, including inability to obtain blood pressure, low oxygen saturation levels, difficulty breathing, or any signs of distress would indicate a need for notification of a physician. She would expect a nurse to provide an assessment of the condition of the resident if they were unable to obtain blood pressure, or if a concern for respiratory distress in a patient. Interview with the DON on [DATE] at 10:20 A.M. revealed that on [DATE] at around 6:00 P.M., she was called into Resident #15's room by STNAs because of concerns for respiratory distress. The DON verified she was unable to obtain blood pressure on Resident #15, using manual and automatic cuff after multiple attempts. The DON verified she did not perform a respiratory, neurological, cardiac, or pain assessment at that time. The DON verified she did not call the physician regarding Resident #15's change of condition and further verified that she did not call the responsible party regarding Resident #15. The DON verified that on the facility's video surveillance, she was the one at 6:10 P.M. speaking to LPN #21 and RN #62 regarding Resident #15 and stated, He's breathing almost like someone who is transitioning, that he is a full code, she did not have a reason to send to hospital, because he would come right back. Interview with STNA #58 on [DATE] at 1:00 P.M. revealed that on [DATE] at approximately 5:15 P.M., Resident #15 was complaining of coughing, to which she helped him set up in bed, provided water, and his meal tray, and he began to eat at that time. During change of shift on [DATE] at approximately 6:00 P.M. with oncoming STNA #34, they entered Resident #15's room to find him grasping at his chest with his hands, his eyes wide open, unresponsive to verbal stimulation and irregular breathing/holding breath. STNAs #34 and #58 immediately exited the room to find the DON, outside of his room. The DON began to talk to Resident #15 to which he did not respond. The DON directed STNA #58 to find his code status in the medical record. STNA #58 went to the nurses' station, found his medical record, and found his code status was a full code, and ran back to tell the DON. STNA #58 told the DON he was a full code and proceeded to find vital sign equipment. The pulse oximeter was applied to the finger of Resident #15 and his oxygen saturation was 76 percent (%). STNA #58 stated the resident's oxygen saturation never was normal (normal is 96 to 100%) and it stayed in the 70's range. Resident #15 had oxygen on via nasal cannula and they were unable to obtain blood pressure with wrist cuff. STNA #58 left the room shortly after, around the same time as the DON, and continued walking rounds with STNA #34. Interview with RN #62 on [DATE] at 1:30 P.M. revealed she was giving report to LPN #21 on [DATE] at approximately 6:00 P.M. when she was told Resident #15 was in distress and the DON was handling it. RN #62 stated she was under the understanding it was an emergency with Resident #15. The DON came to the nursing desk shortly after beginning shift report and was told Resident #15 was having respiratory issues and was unable to obtain blood pressure. RN #62 stated she asked the DON if Resident #15 needed to be sent to the hospital and was told by the DON the hospital will send him right back because his oxygen saturation was 97%. RN #62 verified she did not call the physician or assess Resident #15 at that time because she was transferring care to LPN #21. Attempts to interview LPN #21 during the investigation were unsuccessful. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with VPO #140 on [DATE] at 9:30 A.M. verified LPN #21 would not cooperate with the facility's investigation, and LPN #21 refused to provide a statement on [DATE] and would not return any of the facility's telephone calls to provide a statement. VPO #140 also verified LPN #21 worked for a staffing agency and the staffing agency reported LPN #21 would not return their telephone calls either and was uncooperative with the staffing agency's investigation. Review of the facility's video surveillance outside of Resident #15's room revealed the following events occurred beginning on [DATE] at 5:00 P.M. and ending on [DATE] at 12:17 A.M.: From 5:02 P.M. to 5:13 P.M., a male's voice is heard coughing/yelling with inaudible communication. At 5:14 P.M., a male's voice is heard coughing with inaudible communication. STNA #58 is seen bringing food trays down the hall and states, [Resident #15's first name] calm down, hold on then proceeds to deliver a food tray to another resident's room. Then STNA #58 proceeded to walk into Resident #15's room and Resident #15 stated Can't stop coughing. STNA #58 states I am going to pull you up, then there is inaudible conversation, then states, Do you want a drink, breath through your nose to get that oxygen. STNA #58 walks out of Resident #15's room at 5:17 P.M. At 5:18 P.M., STNA #58 enters Resident #15's room with a food tray. STNA #58 tells Resident #15 that a nurse will come check on you and states she is not a nurse. STNA #58 leaves Resident #15's room and proceeds to deliver food trays to surrounding rooms until 5:20 P.M. and then leaves the hall with the food cart. At 5:40 P.M., a male's voice is heard coughing with inaudible communication, and this is the last time that the male's voice is heard. At 5:58 P.M., STNAs #34 and #58 can be seen entering Resident #15's room and parts of a conversation are heard including a female's voice asking Resident #15 You, ok?' and tells him to breathe through his nose multiple times. No male voice is heard. At 5:59 P.M., STNA #34 enters a room across the hall from Resident #15 and the DON exits the same room and proceeds into Resident #15's room. At 6:00 P.M., STNA #58 exits Resident #15's room and walks down to the nurses' station. STNA #58 is seen running from the nurses' station to Resident #15's room, and a female's voice is heard saying, he does not have a Do Not Resuscitate (DNR) order and form. At 6:01 P.M., the DON leaves Resident #15's room and goes to the nurse's station. At 6:01 P.M., STNA #58 removes the tray from Resident #15's room and states I don't know what's happening. At 6:02 P.M., the DON and STNA #58 are seen outside Resident #15's room, and the DON states he has mesothelioma and lung cancer. STNA #58 leaves Resident #15's room, enters room across the hall, then leaves and proceeds to walk down to the nurse's station. At 6:03 P.M., STNA #58 returns to Resident #15's room with a blood pressure cuff in her hand. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 6:06 P.M., the DON and STNA #58 are seen exiting Resident #15's room. At 6:07 P.M., the DON is seen entering Resident #15's room with a blood pressure cuff in her hand. At 6:10 P.M., the DON is seen exiting Resident #15's room with a blood pressure cuff in her hand, and a female's voice is heard saying, I can't get blood pressure. At 6:12 P.M., the DON is seen leaving off unit. From 6:10 P.M. to 7:33 P.M., no staff enter Resident #15's room. At 7:34 P.M., LPN #21 enters Resident #15's room and talks to the two family members that arrived at 7:32 P.M. At 7:37 P.M., LPN #21 leaves Resident #15's room. From 7:38 P.M. to 11:55 P.M., LPN #21 did not enter Resident #15's room. At 11:54 P.M., STNA #34 enters Resident #15's room and remains in the room for a full minute before exiting and stands at the door and waits for LPN #21. LPN #21 reaches STNA #34 at Resident #15's door and states I don't know why he's so cold. LPN #21 states The room is cold? They both enter Resident #15's room at 11:55 P.M. STNA #34 is heard stating He's dead and LPN #21 states Yeah. At 11:55:59 P.M., LPN #21 exits Resident #15's room stating, And he is a full code and no hospice. LPN #21 walks to the nurse's station and you can hear the bed in Resident #15's room being moved. At 11:56 P.M., LPN #21 reaches the nurse's station and sits there. At 11:57 P.M., STNA #34 exits Resident #15's room carrying a gown and states something to LPN #21 that was inaudible. LPN #21, STNA #34 and STNA #103 have a conversation at the nurse's station. At 11:59 P.M., STNA #103 leaves the nurse's station. At 12:00 A.M., LPN #21 makes a telephone call (to the DON) and states Our guy just passed away. I wanted to send him out but .he is a full code .I can't even get him out of the bed. He is dead weight. I can't get him on the floor. Okay, I'm calling to let you know .I will start CPR and I will yell across the room for the next nurse to call [DATE]. LPN #21 got louder and said I already verified [DON's name]. You knew his situation when you left here. I already verified he was dead, and I called you .Why are you yelling at me .I was at the assisted living (AL) unit, you had me working at AL .I will go in and do CPR. You call the other nurse. LPN #21 is off the telephone and makes comments to STNA #34 before she leaves the nurses station stating Don't act like it's an emergency now. You knew the situation. At 12:02 A.M., LPN #21 sends STNA #34 to tell the long-term care (LTC) nurse (LPN #56) to call 911. LPN #21 then starts down the hall walking. She turns back around towards the nurse's station and sits down again. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled Abuse dated [DATE] revealed residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident property. It is the facility policy to investigate all alleged violations involving abuse, neglect, exploitation or mistreatment. The policy further defines neglect as the failure of the facility, its employee, or facility service to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility policy defines abuse to include the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This deficiency represents non-compliance investigated under Complaint Number OH00154334.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365605	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Milcrest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 730 Milcrest Drive Marysville, OH 43040	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on medical record review, staff interviews, review of the facility's Self-Reported Incidents (SRI), and policy review, the facility failed to timely report allegations of neglect to the State Survey Agency and Local Law Enforcement. This affected one (Resident #15) of three residents reviewed for abuse and neglect. The facility census was 47 residents. Findings include: Review of the closed medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included atrial fibrillation, mesothelioma (an aggressive and rare form of cancer that usually occurs in the thin layer of tissue that lines the lungs or the abdomen), and respiratory failure with hypoxia. Resident #15 died on [DATE] at 12:50 A.M. at the emergency room . Review of the physician orders for Resident #15 revealed an order dated [DATE] for the resident to be a full code. Review of Resident #15's medical record revealed there was no documentation of a blood pressure reading or the inability to obtain blood pressure. There was no documentation that the physician was notified of Resident #15's change in condition. There was no documentation of a respiratory assessment, neurological assessment, pain assessment, or cardiac assessment completed after the Director of Nursing (DON) was alerted by State tested Nursing Aides (STNAs) #34 and #58 of Resident #15's change of condition at 6:00 P. M. Review of the progress note dated [DATE] at 7:00 P.M. revealed Licensed Practical Nurse (LPN) #21 documented Resident #15 was in respiratory distress when this nurse arrived to report for shift. The DON was in the room with the resident. The DON reported all vitals within normal limits and does not see any need to send the resident out to the hospital when the day shift nurse recommended to send him to the hospital. There was no documentation of vital signs, notification of physician, no documentation of respiratory assessment, neurological assessment, pain assessment, or cardiac assessment completed by LPN #21. Review of the facility's SRI control number 248014 revealed the initial report was filed to the State Survey Agency on [DATE] for an allegation of neglect that occurred on [DATE] at 12:00 A.M. The facility did not report the allegation of neglect to Local Law Enforcement until [DATE]. The SRI's summary of the incident revealed on [DATE] at 12:00 A.M., LPN #21 contacted the DON to inform her Resident #15 had expired. The DON questioned LPN #21 if Cardiopulmonary Resuscitation (CPR) had been conducted and LPN #21 stated no. The DON directed LPN #21 to initiate CPR in which the LPN was reluctant to initiate. The DON hung up the telephone and called LPN #56 to initiate CPR on Resident #15. The facility's investigation determined there was a delay and reluctance to initiate CPR on Resident #15 and substantiated the allegation of neglect. (continued on next page)		

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Printed: 08/28/2024
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's SRI control number 248354 revealed the facility initially reported to the State Survey Agency on [DATE] for an allegation of neglect that was reported on [DATE]. The facility initiated an investigation on [DATE]. The facility did not report the allegation of neglect to the Local Law Enforcement until [DATE]. The allegation of neglect was substantiated on [DATE]. The facility's review of video and video audio on [DATE] from 5:00 P.M. to midnight showed the DON failed to assess, monitor, and timely notify the physician of Resident #15's change in condition. The DON stated, He is transitioning and discusses the inability to obtain blood pressure and he was shaking. The facility substantiated the allegation of neglect and concluded the DON did not adequately assess, monitor, and timely notify the physician of Resident #15's change of condition which led to his death. Interview on [DATE] at 1:00 P.M. with the DON confirmed she received a phone call on [DATE] at 12:00 A.M. from LPN #21 and told her Resident #15 had died . The DON stated she told LPN #21 to go start CPR and call 911, to which LPN #21 refused. LPN #21 continued to refuse to start CPR, so the DON hung up the telephone, and she called LPN #56 at 12:02 A.M. to go to the skilled unit and start CPR on Resident #15. The DON verified the facility did not report the allegation of neglect for delay and reluctance to initiate CPR on Resident #15 to the State Survey Agency immediately and did not report it until [DATE]. Interview on [DATE] at 3:30 P.M. with Clinical Director #143 verified the facility did not report the allegation of neglect of Resident #15 by the DON to the State Survey Agency and Local Law Enforcement until the day after ([DATE]) the facility was made aware of an Immediate Jeopardy in neglect ([DATE]). Review of the facility policy titled Accident or Incident Reporting dated [DATE] revealed accidents and incidents are to be promptly and thoroughly reviewed and investigated. Any reasonable cause to believe that a resident has suffered abuse or neglect is to be reported to the Ohio Department of Health (ODH) through the Enhanced Information Dissemination Collection (EIDC) portal. Review of the facility policy titled Abuse dated [DATE] revealed if the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the ODH no later than two hours after the allegation is made. This deficiency represents non-compliance investigated under Complaint Number OH00154334.		

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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** 47988 Based on closed medical record review, review of the facility's video surveillance, staff interviews, review of the facility's Self-Reported Incident (SRI) and investigation, review of the Emergency Medical Services (EMS) run report, review of the facility policy, and review of the American Heart Association (AHA) guidelines, the facility failed to timely initiate Cardiopulmonary Resuscitation (CPR) or contact EMS timely for one resident (#15), who was found unresponsive, without a pulse or respirations, and who was identified as a Full Code status. In addition, once initiated, the facility failed to provide adequate CPR techniques for Resident #15. This resulted in Real and Present Danger, serious life-threatening harm, and ultimate death when Resident #15 did not receive CPR for nine minutes after he was discovered with no vital signs, EMS was not contacted for assistance until ten minutes after the resident was discovered, and when CPR was initiated, staff performed chest compressions while Resident #15 remained in the bed, without a backboard present, which lessened the overall effectiveness of chest compressions. This affected one (Resident #15) of three (#15, #55, and #56) residents reviewed for death in the facility. The facility census was 47. On [DATE] at 4:47 P.M., the Administrator, the Director of Nursing (DON), [NAME] President of Operations #140 and Clinical Director #143 were notified Real and Present Danger began on [DATE] at 11:55 P.M. when the facility failed to immediately initiate CPR for Resident #15 who was a full code and was found unresponsive and without vital signs. State tested Nursing Aide (STNA) #34 and Licensed Practical Nurse (LPN) #21 found Resident #15 dead on [DATE] at 11:55 P.M. LPN #21 was heard stating Resident #15 was a Full Code and not hospice services on the facility's video surveillance. At 11:56 P.M., LPN #21 leaves Resident #15's room and sits at the nursing station and does not make any telephone calls until 12:00 A.M. On [DATE] at 12:00 A.M., LPN #21 telephones the DON to report Resident #15 has deceased , and LPN #21 is reluctant to initiate CPR. At 12:03 A.M., LPN #56 initiates CPR on Resident #15 and completes CPR on Resident #15's bed without a backboard present. At 12:04 A.M., EMS were contacted by LPN #21. LPN #56 continued with CPR until EMS arrives at 12:10 A.M. The Real and Present Danger was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 12:17 A.M., EMS transported Resident #15 to the hospital and the emergency room pronounced Resident #15 dead at 12:50 A.M. On [DATE], Clinical Director #143 submitted their initial SRI. On [DATE], the facility held an ad-hoc Quality Assurance and Performance Improvement (QAPI) committee meeting to discuss and identify the problem and complete a root cause analysis. (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the DON and LPN #93 educated all 16 licensed nurses regarding verification of the resident's code status and when the nurse should complete CPR. Education will be provided to all agency licensed nurses upon their next scheduled shift by the DON/designee. The education included advance directive specifics (Full Code, Do Not Resuscitate Comfort Care Arrest (DNRCCA), and Do Not Resuscitate Comfort Care (DNRCC)), physician required pronouncement of death and steps to performing a code/providing CPR according to AHA guidelines as well as location of crash carts and the supplies/equipment necessary to perform resuscitative measures. On [DATE], the DON and LPN #93 verified all 16 licensed nurses had active CPR certification. On [DATE], the DON, LPN #93 and Clinical Director #143 conducted an audit on all 46 residents' advance directive. The Advance Directive state forms, physician orders, and care plans were audited to ensure all were consistent throughout the medical record. On [DATE], the DON and LPN #93 completed an audit of the facilities crash carts. The equipment and supplies were present on the two crash carts in the facility. Beginning on [DATE], mock codes will be conducted to ensure staff proficiency as well as CPR is performed according to AHA guidelines. Mock codes will be conducted three times weekly to include both licensed nurse shifts as well as nine staff questionnaires weekly regarding understanding of the Advanced Directive policy. Mock codes and questionnaires will be coordinated to include licensed nurses provided by the staffing agency. Both mock codes and questionnaires will be performed at minimum for four weeks by the DON and/or designee. Audit findings will be presented to the QAPI Committee weekly for recommendations. On [DATE], Clinical Director #143 educated all 14 therapists (physical, occupational, and speech) regarding advance directive specifics (Full Code, DNRCCA, and DNRCC) as well as the required response to identifying a resident experiencing a potential life-threatening event. Education was also provided regarding potential for participation in code events whether CPR certified or not. On [DATE], the facility reported LPN #21 to the Ohio Board of Nursing and to the local police for failure to initiate CPR on a resident whose code status was Full Code. Although the Real and Present Danger was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Real and Present Danger) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included atrial fibrillation, mesothelioma, and respiratory failure with hypoxia. Resident #15 died at the emergency roiaognom on [DATE] at 12:50 A.M. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition. Review of the physician orders for Resident #15 revealed an order dated [DATE] for the resident to be a full code. (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 Resident #15's progress notes dated [DATE] at 11:40 P.M. (per video surveillance the time was 11:54 P.M.) revealed LPN #21 was notified by State tested Nurse Aide (STNA) #34 to come to the residents' room to assess. Resident #15 was found laying in bed unresponsive. No signs of breathing noted. LPN #21 attempted to move the resident from the bed to the floor but was unable to. The DON was notified. The crash cart was moved from behind the nurses' station to the resident's room. Staff nurse (LPN #56) continues CPR, with no back board noted. LPN #21 expressed concern of doing ineffective CPR. CPR continues until EMS arrived on scene. Review of the facility's video surveillance outside of Resident #15's room revealed the following events occurred beginning on [DATE] at 11:54 P.M. and ending on [DATE] at 12:17 A.M.: At 11:54 P.M., STNA #34 enters Resident #15's room and remains in the room for a full minute before exiting and stands at the door and waits for LPN #21. LPN #21 reaches STNA #34 at Resident #15's door and states I don't know why he's so cold. LPN #21 states the room is cold? They both enter Resident #15's room at 11:55 P.M. STNA #34 is heard stating He's dead and LPN #21 states yeah. At 11:55:59 P.M., LPN #21 exits Resident #15's room stating, And he is a full code and no hospice. LPN #21 walks to the nurse's station and you can hear the bed in Resident #15's room being moved. At 11:56 P.M., LPN #21 reaches the nurse's station and sits there. At 11:57 P.M., STNA #34 exits Resident #15's room carrying a gown and states something to LPN #21 that was inaudible. LPN #21, STNA #34 and STNA #103 have a conversation at the nurse's station. At 11:59 P.M., STNA #103 leaves the nurse's station. At 12:00 A.M., LPN #21 makes a telephone call (to the DON) and states Our guy just passed away. I wanted to send him out, but .he is a full code .I can't even get him out of the bed. He is dead weight. I can't get him on the floor. OK I'm calling to let you know .I will start CPR and I will yell across the room for the next nurse to call [DATE]. LPN #21 got louder and said I already verified [DON's name]. You knew his situation when you left here. I already verified he was dead, and I called you .Why are you yelling at me .I was at the assisted living (AL) unit, you had me working at AL .I will go in and do CPR. You call the other nurse . LPN #21 is off the telephone and makes comments to STNA #34 before she leaves the nurses station stating Don't act like it's an emergency now. You knew the situation. At 12:02 A.M., LPN #21 sends STNA #34 to tell the long-term care (LTC) nurse (LPN #56) to call 911. LPN #21 then starts down the hall walking. She turns back around towards the nurse's station and sits down again. At 12:03 A.M., LPN #56 arrives at the nurse's station and states He is a full code honey as she is talking on the telephone and asking where the crash cart is. We need to do CPR, and someone needs to call 911. STNA #34 returns and is talking to LPN #21 while she is sitting at the nurse's station. LPN #56 is still on the telephone, asks, Where is he at? STNA #34 follows and states, that one and points to Resident #15's room. LPN #56 enters Resident #15's room at 12:03 A.M. LPN #56 is heard saying I am. I am. I am. LPN #56 can be heard doing compressions as the bed squeaks with each compression. (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 12:04 A.M., STNA #34 enters Resident #15's room. LPN #56 is heard saying His name is [First name of Resident #15] what? STNA #34 steps out of the room and looks at the name plate and states [Resident #15's first and last name]. STNA #34 asks LPN #56 You called 911, right?. LPN #56 states, We still have to do CPR. At 12:04:34 A.M., LPN #21 is seen walking up to Resident #15's room with the crash cart. As she enters the room, LPN #21 asks LPN #56 Do we have a backboard?. The backboard can be seen on the back of the crash cart by the camera. STNA #34 states I don't know. LPN #56 asks LPN #21 if she has called 911. LPN #21 replies Yeah. LPN #56 asks LPN #21, Has the responsible parties been notified? LPN #21's replies You don't have to do all that. LPN #56 states, He is a full code. Yes, we do. LPN #21 states, I'm not saying you don't have to do CPR. I'm saying doing it in the bed its ineffective. LPN #21 asks Where is the backboard? LPN #56 yells back, I don't know. We don't have one. You are in a nursing home. Noises can be heard coming from the room but not distinguishable. LPN #56 states Help me get him on the floor. LPN #21 states There should be a backboard. LPN #56 repeats, I need some help. Are you kidding me? This is someone's life here. Give me the attitude later. LPN #21 is heard stating, I need to start my rounds. At 12:10 A.M, EMS arrives and STNA #34 escorts EMS to Resident #15's room. Code verification asked of nurses. Both nurses respond, He is a full code. At 12:17 A.M., EMS is seen transporting Resident #15 out of the room. Review of the facility submitted SRI revealed an allegation of neglect was made known on [DATE]. The involved resident was identified as Resident #15, and the alleged perpetrator was LPN #21. The date of occurrence was indicated to be [DATE] and the SRI's initial report was noted to have been submitted on [DATE]. The SRI's summary of the incident revealed on [DATE] at 12:00 A.M., LPN #21 contacted the DON to inform her Resident #15 had expired. The DON questioned LPN #21 if CPR had been conducted and LPN #21 stated no. The DON directed LPN #21 to initiate CPR in which the LPN was reluctant to initiate. The DON hung up the telephone and called LPN #56 to initiate CPR on Resident #15. The facility's investigation determined there was a delay and reluctance to initiate CPR on Resident #15. Review of LPN #56's undated witness statement revealed on [DATE] at 12:02 A.M., LPN #56 was notified by the DON to go to the skilled unit because Resident #15 was in cardiac arrest and a full code. LPN #56 immediately went to the skilled unit and LPN #21 was sitting at the nurse's station. LPN #56 went into Resident #15's room, and Resident #15 was gray, no sign of rise and fall from chest, mouth open and no verbal/non-verbal response when she spoke his name. LPN #56 started CPR and shouted out for the nurse (LPN #21) to assist with CPR. LPN #21 entered the room and began to argue regarding the position of the resident that he was in a bed and that CPR would be ineffective. LPN #56 stated CPR should have been started until the resident could be placed on a flat/firm surface and continued to provide CPR compressions after a count of 20 compressions. Review of STNA #34's undated witness statement revealed on [DATE] at about 11:00 to 11:30 P.M. (actual time was 11:54 P.M. per video surveillance), STNA #34 found Resident #15 unresponsive and called LPN #21. LPN #21 called the DON and EMS. LPN #21 asked STNA #34 to call the other nurse, LPN #56. LPN #56 and STNA #34 got Resident #15 on the floor and the nurses did CPR before the squad came. (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 the DON's witness statement dated [DATE] revealed she received a telephone call from LPN #21 at midnight on [DATE] stating Resident #15 had died . The DON asked for a statement of her involvement in the code. LPN #21 stated she had not initiated the code. The DON stated Resident #15 was a full code and she needed to get off the telephone and initiate CPR. The DON repeated to LPN #21 to get off the telephone. LPN #21 continued to argue with the DON. The DON raised her voice and told LPN #21 to get off the telephone and go do CPR. The DON immediately called LPN #56 on the long-term hall and told LPN #56 there was a code in the building in [Resident #15]'s room and needed her to help as LPN #21 had not initiated the code. The DON was on the telephone until LPN #21 was in the room initiating compressions. Review of the EMS run report dated [DATE] revealed EMS received the call on [DATE] at 12:04 A.M. Resident #15 was transported to the local hospital and provided with advanced life support interventions by EMS. Interview with STNA #34 on [DATE] at 10:30 A.M. revealed she found Resident #15 cold and non-responsive and alerted LPN #21 of his status. STNA #34 verified LPN #21 did not initiate any life saving measures including CPR, and CPR was initiated by LPN #56 once she arrived on the unit. Interview with the DON on [DATE] at 1:00 P.M. confirmed she received a telephone call on [DATE] at 12:00 A.M. from LPN #21. LPN #21 told her Resident #15 had died . The DON stated she told LPN #21 to go start CPR and call 911, to which LPN #21 refused. LPN #21 continued to refuse to start CPR, so the DON hung up the telephone, and she called LPN #56 at 12:02 A.M. to go to the skilled unit and start CPR on Resident #15. Interview with Nurse Practitioner (NP) #75 on [DATE] at 1:30 P.M. confirmed there was no communication from the facility regarding Resident #15's change of condition, emergency services, CPR and/or Resident #15's death. NP #75 confirmed she met Resident #15 on [DATE] and during Resident #15's assessment, Resident #15 requested to be a full code. NP #75 confirmed CPR should have been initiated immediately when LPN #21 found Resident #15 unresponsive without vital signs. Interview with the DON on [DATE] at 10:30 A.M. verified that facility policy and standard adult CPR was 30 compressions to two breaths ratio, and LPN #56 did compressions of 20 and a pulse check which were not within the guidelines of the correct performance of CPR. The DON verified the backboard was present on the crash cart on [DATE] at 12:04 A.M. and LPN #56 should have utilized the backboard when completing CPR on Resident #15. Interview with LPN #56 on [DATE] at 11:43 A.M. revealed she received a telephone call from the DON on [DATE] at 12:02 A.M to go start CPR on Resident #15 who was a full code because LPN #21 refused to start CPR. When she arrived at the skilled unit, both LPN #21 and STNA #34 were at the nurse's station. LPN #56 was directed to the residents' room at approximately 12:04 A.M., where she found Resident #15 and he was gray, he had no sign of rise and fall from his chest, mouth open and no verbal/non-verbal response when she spoke his name. LPN #56 verified she began compressions on Resident #15 while in bed with no backboard and no backboard was used for the entirety of CPR. LPN #56 verified she provided CPR to Resident #15 with 20 compressions and then would check for a pulse. LPN #56 verified she provided CPR to Resident #15 until the medics arrived and took over. Attempts to interview LPN #21 during the investigation were unsuccessful. (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 the [NAME] President of Operations (VPO) #140 on [DATE] at 9:30 A.M. verified LPN #21 would not cooperate with the facility's investigation, and LPN #21 refused to provide a statement on [DATE] and would not return any of the facility's telephone calls to provide a statement. VPO #140 also verified LPN #21 worked for a staffing agency and the staffing agency reported LPN #21 would not return their telephone calls either and was uncooperative with the staffing agency's investigation. Review of the facility policy titled Adult CPR dated [DATE] revealed to provide high-quality CPR per AHA Basic Life Support guidelines, a licensed staff member who was certified in CPR/BLS (basic life support) shall initiate two rescue breaths after 30 compressions, continue at 30 to two ratio. Review of the AHA guidelines dated [DATE] revealed the AHA urged all potential rescuers to immediately start CPR unless a valid DNR order was in place or there were obvious clinical signs of irreversible death present (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) or initiating CPR could cause injury or peril to the rescuer. This deficiency represents non-compliance investigated under Complaint Number OH00154334.		