STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366267	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Mayfield Village, Inc	290 North Commons Blvd Mayfield Village, OH 44143

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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** Based on closed medical record review, review of 911 communications, review of the American Heart Association (AHA) guidance for adult Cardiopulmonary Resuscitation (CPR), review of Ohio Revised Code related to pronouncement of death, facility policy review, and interview, the facility failed to ensure Resident #46, who had a Full Code status, received appropriate and timely emergency response (including CPR) consistent with the resident's advance directives, facility policy, professional standards of practice, and physician expectations. This resulted in Immediate Jeopardy and Actual Harm with subsequent death on [DATE] at 7:20 A.M. when Resident #46 was found unresponsive (without vital signs) and Licensed Practical Nurse (LPN) #509 discontinued cardiopulmonary recusation (CPR) without a physician order, without emergency medical services (EMS) present, and without the qualifications necessary to pronounce the resident deceased . Additionally, LPN #510 failed to ensure EMS response by canceling or miscommunicatingwith 911, resulting in EMS never arriving on the scene. This affected one resident (#46) of eight residents reviewed for change of condition. The facility census was 45. On [DATE] at 4:45 P.M. the Administrator, Director of Nursing (DON) and Corporate Regional Nurse (CRN) #603 were notified Immediate Jeopardy began on [DATE] at approximately 7:20 A.M., when Resident #46 was found unresponsive, and facility staff failed to follow the facility CPR policy requiring immediate initiation of CPR, activation of 911, and continuation of CPR until EMS arrival or physician instruction. Instead, CPR was stopped prematurely, EMS never entered the facility, and the physician did not authorize cessation of life-saving efforts. The resident was subsequently pronounced deceased at the facility. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 7:53 A.M. the Administrator notified CRN #603 and requested assistance with an investigation into the death of Resident #46. On [DATE] at 11 :00 A.M. immediate education was initiated for licensed nurses in the facility by CRN #603, regarding the facility policy titled Change in Condition, facility policy titled CPR, staff emergency response expectations, education related to physician was required to determine time of death/discontinuation of resuscitation efforts and the facility notification procedure. Education was completed on [DATE] at 6:00 P.M. when five of seven (5/7) Registered Nurses (RN) (one RN was out on leave and one RN was considered as needed (PRN) and would receive education upon return) and eight of eight (8/8) Licensed Practical Nurses (LPN) were educated. The facility also implemented a plan that upon hire, all new licensed nurses would be educated by the Director of Nursing (DON)/designee regarding the above information. Agency nurses and any PRN licensed nurse who were not actively working in the facility at that ti me would be educated by the DON on the information prior to their next working shift. On [DATE] at 12:00 P.M. CRN #603 audited 47/47 in-house resident charts to verify signed Advanced Directives were in place. The facility then implemented a plan forthe Administrator/designee to audit code status for incoming admissions daily for two weeks and PRN thereafter. On [DATE] at 2:00 P.M. CRN #603 audited crash carts located on each unit (Timberline and Wildwood) to ensure all necessary supplies were available and Automated External Defibrillator (AED) was centrally located. On [DATE] (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	at 5:25 P.M. an Ad Hoc Quality Assurance meeting was held with the Administrator, DON/Interim IP, RNC #603 and Medical Director (MD) #606 related to event with discussion of plan including education, root cause, and audits. MD #606 agreed with the facility plan at that time. On [DATE] the Administrator and DON verified active CPR Certification for seven of seven RNs and eight of eight LPNs. On [DATE] at 7:00 P.M. CRN #603 completed an audit of medical records for all residents who had expired in the facility and had a full code for the past six months. On [DATE] the DON initiated interviews of three licensed nurses daily for one week and then three times a week for three weeks and then as needed to ensure the licensed nurse was able to identify when CPR was required for a resident as well as the correct procedure to initiate emergency response to the facility. Beginning on [DATE] the facility implemented a plan for the Administrator/designee to audit code status for incoming admissions daily for two weeks and as needed thereafter. On [DATE] the facility initiated mock code drills by the DON every shift for one week. The DON/designee would then continue these on one random shift three times a week for three weeks and then as needed to ensure licensed nurses were able to appropriately identify when CPR was required and appropriate initiation of emergency response protocols. Any concerns identified with the audits would be forwarded to QAPI committee weekly for four weeks and as needed for immediate follow-up. The Administrator would be responsible for ongoing compliance. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and were monitoring to ensure on-going compliance. Findings include: Review of Resident #46's closed medical record revealed an admission date of [DATE] with diagnoses including ataxia (lack of muscle control), systemic inflammatory response syndrome, dysphagia (difficulty swallowing), communication deficit, weakness, abnormalities of gait, dysarthria (motor speech disorder), aphasia (impaired ability to communicate), heart failure, hypertension, atherosclerotic heart disease, type two diabetes, convulsions, Parkinsonism, and hyperlipidemia. Record review revealed Resident #46 expired in the facility on [DATE]. Review of medical record Face Sheet Advanced Directives revealed the resident had a code status of Full Code. No Do Not Resuscitate (DNR) was designated. Review of the Minimum Data Set (MOS) 3.0 Entry assessment dated [DATE] revealed Resident #46 entered the facility from a short-term hospital on [DATE]. Review of the medical record clinical admission documentation dated [DATE] at 4:45 P.M., authored by Registered Nurse (RN) #601, revealed Resident #46 had impaired short-term memory but intact long-term memory. Resident #46 was alert and oriented to self, place and time, sometimes understood others, and was limited to making concrete requests. Resident #46 had unclear speech but was able to understand others. Resident #46 was incontinent with bowel and bladder and wore a brief. Resident #46's mobility was limited to changing positions. Review of the baseline care plan dated [DATE] revealed Resident #46's Advanced Directives were not addressed. Review of the progress note dated [DATE] at 1:17 P.M. authored by the Administrator revealed the InterdisciplinaryTeam (IDT) met with Resident #46 and family to discuss plan of care and discharge planning. Resident #46's code status was designated 'FULL CODE. Resident #46 planned to return home with his son. Review of the physician orders dated [DATE] to [DATE] revealed no physician orders regarding an Advanced Directive. Review the medical record revealed on [DATE] at 2:05 A.M. vital signs documented by LPN #510 revealed Resident #46's blood pressure was 130/60 millimeters of mercury (mmHg), oxygen saturation 96 percent, pulse 83 beats per minute, respirations 20 per minute and a temperature of 97.1 degrees Fahrenheit (F). Review offacility document titled Medication History authored by LPN #510 revealed on [DATE] at 2:07 A.M. Resident #46 refused Acetaminophen 325 milligrams (mg) (analgesic), Atorvastatin 80 mg (lowers cholesterol), Carvedilol 3.125 mg (treats high blood pressure and heart failure), and Keppra 100 mg/milliliter (ml) (antiseizure). Resident #46 refused to open his mouth to take medication. The note included Physician #600's team was paged and made aware. Review of the nursing progress note dated [DATE] at 4:28 A.M. authored by LPN #510 revealed Resident #46 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and the DON who verified Receptionist# 576 and LPN #510 were in the video. Review of the Vital Statistics Certificate of Death revealed Resident #46 expired in the facility on [DATE] at 7:20 A.M. Cause of death was myocardial infarction and coronary artery atherosclerosis. No autopsy was performed. An interview on [DATE] at 12:50 P.M. with Registered Nurse (RN) #601 revealed Resident #46 was stable on admission during his admission assessment. A meeting was held with the family because Resident #46 was eating less, but Resident #46's family wanted Resident #46 to remain a Full Code status and was not ready to consider hospice. An interview on [DATE] at 1:14 P.M. with the Administrator revealed the facility had an interdisciplinaryteam (IDT) meeting (date not provided) with the family regarding Resident #46's functional decline, but the family was not ready for hospice or a code status change. Resident #46 was to remain a Full Code as a result of this meeting. An interview on [DATE] at 2:00 P.M. with LPN #509 revealed she worked [DATE] and her shift started at 7:00 A.M. She stated she received report from LPN #510 stating Resident #46's labs were not good, and Resident #46 was not doing good. During narcotic count at the start of the shift, Physician #600 called with an order to send Resident #46 to the hospital. When she walked into Resident #46's room to obtain vital signs for transfer, she stated Resident #46 was unresponsive and did not have a blood pressure. She stated she called for LPN #510. LPN #510 told her Resident #46 was a Full Code. LPN #509 stated she felt it was not medically appropriate to start CPR. LPN #509 stated Resident #46 had a hard chest, was blue, his extremities were stiff, and his mouth was stiff. She stated LPN #510 was to call 911 and LPN #510 called Physician #600 and Resident #46's family. LPN #509 also stated there was no RN in the building at that time and stated she did not know why EMS was not in the room. An interview on [DATE] at 4:30 P.M. with the DON revealed if a resident was a Full Code the nurse was to initiate CPR and wait for EMS to arrive so EMS could take over and call the time of death. A physician could also call the time of death, only a physician could determine if compressions could be stopped and sometimes the physician would speak with EMS to make these determinations. An interview on [DATE] at 6:59 A.M. with LPN #510 revealed Resident #46's baseline was a poor communicator, and he was becoming more lethargic. On [DATE], Resident #46 was still able to answer yes or no questions or squeeze her hand. She stated she called the on-call NP around 8:00 P.M. regarding Resident #46's decline in condition. At 2:00 A.M. vital signs were obtained again, and Resident #46 did not want to take his medications. She stated she called the NP again at 4:00 A.M. and received orders for a chest x-ray. As stated, she was putting in the x-ray orders, she received the results of Resident #46's labs. The NP was paged again. Physician #600 called back at 7:00 A.M. with an order to send Resident #46 to the hospital. LPN #510 stated LPN #509 went to the resident's room while she called 911 to set up a ride to the hospital. LPN #510 stated LPN #509 told her Resident #46 was unresponsive. LPN #510 stated she observed Resident #46 to be cold to touch, his back was still warm, and his brief was wet with urine and stated no rigor mortis had set in and there was no pooling of blood in extremities. The LPN indicated it was like Resident #46 had recently passed away. LPN #510 stated she had to dig for information to verify Resident #46's code status. LPN #510 verified the police came to the facility and verified she told the police there was no emergency. LPN #510 also stated CPR was stopped because LPN #509 decided to stop CPR. LPN #510 also stated she did not know why EMS never came to the facility. She stated the physician declared Resident #46 deceased after CPR was stopped. LPN #510 verified at no time was EMS in the room to assist with CPR or to pronounce Resident #46's death. LPN #510 statedthefacilitypolicywasto have EMS end the code and pronounce a resident deceased . An interview on [DATE] at 9:50 A.M. with LPN #509 revealed she observed Resident #46 to be blue, his mouth was stiff and he was in rigor mortis, with no blood pooling. However, the LPN stated rigor mortis was in his hands because his fingers were curled in. LPN #509 stated she was told Resident #46 was a Full Code, and she initiated CPR, but she thought Resident #46's sternum was too hard, so she stopped. LPN #510 was in the room when CPR was stopped. LPN #509 verified a police officer was never in the room, and EMS never entered the room. She was not sure if EMS ever came to the facility. LPN #509 stated the physician declared Resident (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#46 deceased after talking to LPN #510. LPN #509 verified the facility policy was to call 911 and continue CPR until the EMS arrived then call the physician and family while EMS had taken over. An interview on [DATE] at 10:06 A.M. with the DON revealed the facility policy if a resident was unresponsive the nurse was to check the resident's code status. If the resident was a Full Code, they were to call 911 and continue CPR until EMS arrived on the scene. EMS would take over; the nurse would present and gather information and start paperwork at that time. The DON stated only a physician could determine when to stop CPR, and usually EMS would call the physician. An interview on [DATE] at 11:13 A.M. with Physician #600 revealed he did call the facility at 7:00 A.M. on [DATE] with an order to send Resident #46 to the hospital. Physician #600 stated a nurse called him back and stated Resident #46 was blue. He stated he asked the nurse what Resident #46's code status was, but the nurse did not know. Physician #600 stated he told the nurse to start Advanced Cardiac Life Support (ACLS) until the advanced directives were verified. He stated the nurse told him EMS was on the scene; therefore, he waited for a call back from EMS but never received a call back. He verified he did not tell the nurses to stop CPR or call the time of death.During the interview, Physician #600 indicated facility staff did not act appropriately because the nurse called to tell him Resident #46 was cold and appeared deceased . The nurse was to initiate ALCS then call the physician when a resident was a Full Code. An interview on [DATE] at 11:37 A.M. with Resident #46's Emergency Contact, Responsible Party #602 revealed at no time did the family change Resident #46's code status. Resident #46 was to be a Full Code. She stated the facility called her on [DATE] at 7:45 A.M. stating her dad was found non-responsive; they gave CPR, but he did not respond. An interview on [DATE] at 11:45 A.M. with CRN #603 verified there were no additional telephone orders in the closed medical record for Resident #46 to indicate a change in code status had ever occurred from the resident's desire to maintain advance directives for a full code status. An interview on [DATE] at 12:00 P.M. with Fire Chief #604 revealed the facility called 911 on [DATE] but hung up. When the facility was reached, they stated there was no emergency; therefore, no EMS was sent to the facility. There was no run report because the facility declined service. An interview with the Administrator on [DATE] at 2:45 P.M. revealed according to her investigation Resident #46 did not have signs of distress during the night and when found in the morning, Resident #46 had the beginning signs of death. The Administrator also explained that the facility utilized an on-call system with the Cleveland Clinic NPs that were on-call until 6:00 A.M. then the NPs would call the physicians. The Administrator also stated an interview with the aide who performed postmortem care revealed Resident #46 was stiff, but they were still able to move his body. An interview on [DATE] at 8:50 A.M. with Funeral Home Employee #605 revealed the funeral home was to produce the original death certificate upon arrival to the facility and would fill out the vital information, the death certificate was then sent to the physician to sign and fill in the medical information. Either the funeral home could write the time of death if provided by the facility or the physician would write the time of death. The funeral home revealed they received a phone call from the facility on [DATE] at 9:15 A.M. and the facility stated the time of the resident's death was 8:20 A.M. The funeral home removed Resident #46's body at 11:35 A.M. An interview on [DATE] at 10:45 A.M. with Receptionist #576 revealed she did not call 911 on [DATE] but they called the facility, and she transferred the call to both nurse stations, but no one answered. She stated when she walked to the nurse's station, she was told the nurses were in Resident #46's room. She knocked on the door because the door was shut but when she opened the door the curtain was pulled, therefore she could not see Resident #46 or nurses and could not state which nurse told her to cancel the 911 call. By the time she came back to her desk, a police officer was walking in and asked if anyone needed help. She stated she told the police officer that no one needed help. Review of facility policy titled, CPR- CARDIOPULMONARY RESUSCITATION POLICY, dated [DATE], revealed it was the policy of the facility that basic life support would be provided, including CPR, when a resident required such emergency care prior to the arrival of emergency medical services, that was consistent with the advance directive. In the absence of a Do Not (continued on next page)

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