STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445480	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waters of Springfield LLC	704 5th Avenue East Springfield, TN 37172

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** Based on policy review, American Heart Association (AHA) Adult Basic Life Support Algorithm for Healthcare Professionals dated 2025, Rules of the Tennessee Board of Nursing review, Tennessee Code Annotated (TCA) rules review, medical record review, 911 audio recording review, facility video footage review, facility investigation, Employee file review, Emergency Medical Services (EMS) record report review, County Emergency Communication and interviews, the facility failed to provide continuous Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for 1 of 3 (Resident #1) sampled residents reviewed for CPR. Resident #1 was a vulnerable resident who was found on [DATE] at 6:07 AM, in the bathroom, on his knees slumped over the commode unresponsive. Resident #1 was a full code status (wanted all possible lifesaving, resuscitative measures taken) and CPR was not started when he was found unresponsive. The facility's failure to perform continuous CPR on Resident #1 resulted in Immediate Jeopardy and placed vulnerable and cognitively impaired residents with a full code status at risk. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Administrator was notified of the Immediate Jeopardy on [DATE] at 1:54 PM in the Administrator's Office. The facility was cited at F-678 at a scope and severity of J, which is Substandard Quality of Care. A partial extended survey was conducted on [DATE]. The IJ was effective from [DATE] through [DATE]. The IJ was removed on [DATE]. An acceptable Removal Plan, which removed the immediacy of the Jeopardy, was received on [DATE] at 12:15 PM. The corrective actions were validated by the surveyor on [DATE]. The facility's noncompliance at F-678 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the undated facility policy titled Cardiopulmonary Resuscitation, revealed .It is the intent of the facility to ensure that all residents suffering a cardiac or respiratory arrest will receive treatment of CPR unless the resident has a Do Not Resuscitate Order.Basic CPR is defined as artificial respiration accompanied by external cardiac compressions.CPR will be performed by licensed nursing or staff trained in CPR.Assess resident to determine Respirations have ceased/palpate or auscultate for absence of pulse/heartbeat.nurse will assess the resident for absence of heartbeat by using a stethoscope or palpate pulses and assess for absence of Respirations. Call for assistance.If a resident has a cessation of heartbeat or a cessation of respiration.delegate a person to page for assistance, call 911.All available licensed nurses and staff trained in CPR will respond promptly to the Code and assist as needed.Place the resident on firm surface.Initiate basic life support .Maintain basic life support until ambulance arrives for transfer to hospital.Notify physician and responsible party of the change in condition.Complete documentation in the Nurse's Notes. 2. Review of the AHA Adult Basic Life Support Algorithm for Healthcare Professionals revealed, Verify scene safety, check for (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	responsiveness, check for responsiveness, shout for nearby help, activate emergency response system, send someone to get AED/defibrillator, look for no breathing or only gasping, and check pulse (simultaneously) .no breathing .pulse not felt start CPR .use AED/defibrillator as it is available .continue until ALS [advanced life support] professionals take over . 3. Review of Rules of the Tennessee Board of Nursing Regulations of Licensed Practical Nurses (LPNs), dated [DATE], revealed .The LPN scope of practice is a directed scope of practice and requires appropriate supervision. The LPN, practicing under the supervision of an RN, APRN [Advanced Practice Registered Nurse], licensed physician or dentist .Contributes to the nursing assessment by collecting, reporting, and recording objective and subjective data .Plans for patient care, including .Planning episodic nursing care for a patient whose condition is stable or predictable .Implements nursing interventions and prescribed medical regimens in a timely and safe manner .Collaborates and communicates relevant and timely patient information with patients and other health team members to ensure quality and continuity of care, including .Patient status .Assigns and delegates nursing activities appropriately .Delegate to another only those nursing measures for which that person has the necessary skills and competence to accomplish safely .Task does not require assessment, interpretation, or independent decision-making during its performance or at completion.Selected patient and circumstances of the delegation are such that delegation of the task poses minimal risk to the patient and the consequences of performing the task improperly are not life-threatening . 4. Review of Tennessee TCA 68-3-511 for a Registered Nurse (RN) determining and/or pronouncing death in a nursing home revealed under the following circumstances the RN may determine and pronounce a resident's death, The deceased was a resident of a nursing home; . Death was anticipated, and the attending physician or nursing home medical director has agreed in writing to sign the death certificate. The agreement by the attending physician or nursing home medical director must be present and with the deceased at the place of death; .The nurse is licensed by the state; and .The nurse is employed by the nursing home in which the deceased resided; . Review of Tennessee Code Annotated TCA 63-7-108 and standard 1000-02-.02 LICENSED PRACTICAL NURSE LIMITED, DIRECTED SCOPE OF PRACTICE revealed, (1) Licensed Practical Nurses have knowledge and preparation in nursing, but not to the extent required of Registered Nurses. Licensed Practical Nurses may only perform activities to the extent that the activity is included in the basic practical nurse curriculum .The LPN scope of practice is a directed scope of practice and requires appropriate supervision . 5. Review of medical record revealed Resident #1 was admitted to this facility on [DATE], with diagnoses including Thrombocytopenic disorder, Alcoholic Cirrhosis (advanced stage of chronic [NAME] scarring caused by long-term, heavy alcoholic use) and Hepatic Encephalopathy (serious, potentially reversible brain dysfunction caused by liver failure or cirrhosis, where the liver cannot filter toxins from the blood). Review of the Order Detail dated [DATE] at 7:29 PM, revealed an order for Zofran (medication to prevent nausea) Oral Tablet 4 Milligram (mg), give 1 tablet by mouth every 6 hours as needed for nausea/vomiting for 7 days. This was listed as a Physician's Standing Order. Review of the Care Pan dated [DATE], revealed Resident #1 had .elected/executed: FULL CODE status [[DATE]].impaired cognition/function or impaired thought process.require psychotropic medication to help manage and alleviate.hallucinations and/or delusions.risk for falls. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated Resident #1 was moderately cognitively impaired. Resident #1 required the use of a wheelchair and required partial to moderate assistance with toileting transfers and ambulation up to 10 feet. Review of the February 2026 Medication Administration Record (MAR) revealed Zofran 4 mg was administered to Resident #1 at 9:00 PM on [DATE]. There was no documentation of the effectiveness of (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported Resident #1 went to the bathroom shortly before and had not come out. CNA B knocked on the restroom door and opened the door after receiving no response. Resident #1 was slumped over the toilet. CNA B did not touch the resident and went to get the nurse. (Named LPN A) immediately went to check on resident [#1]. d. [DATE] at 6:12 AM, LPN A notified the DON and verified Resident #1's Advance Directive. e. [DATE] at 6:14 AM, LPN A initiated emergency response, took the crash cart to (Resident #1's) room, called 911 from the facility phone at the nurses' station, and was told to hang up and call cell phone from resident [#1] room. f. [DATE] at 6:17 AM, LPN A called 911 and Resident #1 was assessed for signs of life by the 911 operator, Resident #1 laid on his back by LPN A to evaluate breathing status. Resident #1 was not breathing, was cold to touch and his face was blue in color. (According to the above video recording LPN A first went into Resident #1's room on [DATE] at 6:09 AM and re-entered at 6:20 AM, 11 minutes after originally discovering Resident #1). LPN A lay the Resident on his back to evaluate him. LPN A remained on the phone with 911 until the arrival of EMS. g. [DATE] at 6:23 AM, First responders arrived. h. [DATE] at 6:24 AM, Resident #1's roommate was relocated to another room. i. [DATE] at 6:25 AM, EMS arrived and no CPR was initiated due to signs of obvious death. j. [DATE] at 6:30 AM, Resident #1 was pronounced deceased by paramedics. 8. Review of Progress Notes dated [DATE] at 7:07 PM (late entry entered on [DATE] at 7:07 PM, 3 days after the incident with Resident #1 occurred), revealed LPN A documented .[Resident #1's] Roommate turned on call light, tech [CNA B] answered around 5:45 AM, and immediately reported resident (#1) down in bathroom. Nurse checked on resident, called DON, code blue, 911, NP [Nurse Practitioner] and rp [responsible party/representative]. Crash cart was pushed down, 911 on phone with nurse as she went to resident. Nurse notified 911 that resident was pulled off toilet, face was blue, no pulse, not alert & orient [oriented] and cold to touch. EMS/911 came in and took over . There were discrepancies observed in the facility's timeline, EMS documentation, interviews, and the observations obtained from the facility video footage. Review of facility's video footage from [DATE], revealed CNA B entered Resident #1's room at 6:07 AM. In addition, the facility's timeline stated LPN A initiated emergency response, took the crash cart to Resident #1's room, and called 911 from the nurses' station at 6:14 AM. The 911 call log revealed 911 was called at 6:17 AM. The facility video footage revealed LPN A took the crash cart to Resident #1's room at 6:20 AM. Interviews with staff revealed LPN A did not page a Code Blue and the LPN G (the other nurse working that night) was unaware there was an emergency situation in progress. 9. Review of the facility's undated investigation Conclusion statement of the events from [DATE], revealed the facility alleged CNA B found Resident #1 in the bathroom unresponsive and slumped over the toilet after she was alerted by his roommate that Resident #1 had been in the bathroom for a prolonged period of time. CNA B alerted LPN A of Resident #1's change in condition and when LPN A arrived in Resident #1's room, he remained slumped over toilet, cold to touch and unresponsive. LPN A called the Director of Nursing (DON) and then 911. LPN A made a second call to 911 from her cell phone and could not assess breathing status of Resident #1 due to his position. The 911 operator then instructed LPN A to reposition Resident #1 on his back and LPN A verified Resident #1 was not breathing and was blue in the face. It was relayed that Resident #1 had skin tears to the face caused by his face resting on the toilet seat. The nurse then allegedly left the room due to signs of obvious death and allegedly met with EMTs prior to their entry into Resident #1's room. After EMS assessed Resident #1, it was determined that he was deceased and was pronounced dead at 6:30 AM. 10. Review of the DON's written statement dated [DATE], revealed LPN A was educated regarding proper CPR policy and procedures as well as notifications. 11. Review of a Witness Statement by Resident #7 (Resident #1's roommate) dated [DATE], revealed Resident #7 was in bed and heard Resident #1 go (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	into the bathroom and didn't hear anything else for about 20 minutes and alerted staff by using the call light. 12. Review of a hand-written Witness Statement by LPN A dated [DATE] and received over the telephone by the Administrator, revealed Resident #1 was observed with his knees bent, arms out, and horizontal over the toilet. While on the phone with 911 (operator) LPN A removed Resident #1 from the toilet and laid Resident #1 on the floor while on the phone with 911. Resident #1 had no pulse, was not responsive, was blue in the face and cold to touch. Review of a type-written Witness Statement by LPN A dated [DATE], revealed LPN A was notified by a CNA that Resident #1 was in the bathroom. LPN A checked on the Resident, notified the DON, called 911 and staff told of code blue. The crash cart was taken to Resident #1's room and Resident #1 was assessed while LPN A was on the phone with 911. Resident #1 was not alert, had no pulse, his face was blue and his skin was cold to the touch. 13. Review of a type-written Witness Statement by CNA B dated [DATE], revealed CNA B saw Resident #1 at approximately 4:00 AM. CNA B documented the Resident was alert and she had provided a basin and urinal to him and told him to call if he needed anything. At approximately 6:00 AM to 6:10 AM, Resident #1's roommate pushed his call button and notified staff that Resident #1 went to the bathroom shortly before and had not come out. CNA B knocked on the bathroom door and received no response. CNA B opened the door to the bathroom and observed Resident #1 slumped over the toilet. CNA B did not touch Resident #1 and immediately went to get the nurse. CNA B heard the nurse say code blue and the nurse took the crash cart to the room. CNA B and CNA C began closing resident room doors and clearing the hall. CNA B then observed Resident #1 had been placed on his back by the nurse. CNA B did not witness LPN A or EMS perform CPR. 14. Review of a type-written Witness Statement by CNA C dated [DATE], revealed CNA C entered Resident #1's room with LPN A and CNA B at approximately 6:00 AM to 6:10 AM after CNA B had observed Resident #1 in his bathroom slumped over the toilet unresponsive. LPN A called the DON and while at the nurses' station alerted staff to Code Blue. LPN A obtained the crash cart while she was on the phone. CNA C did not witness CPR being performed for Resident #1. 15. Review of the employee file for LPN G revealed a hire date of [DATE]. The file included a completed Orientation checklist which included competencies for nursing responsibilities during cardiac arrest, verbalize the policy for Do Not Resuscitate (DNR) orders/Advanced Directives, use of airways (a device used to administer oxygen and high-quality CPR), Ambu bags (handheld, manual device used to provide breaths to someone who cannot breathe adequately), checking the crash cart, and a valid CPR certification. Review of the schedule dated [DATE], revealed LPN G was the other LPN scheduled for 7:00 PM to 7:00 AM shift. Review of the employee file for LPN A (Resident #1's assigned nurse on the night of [DATE]) revealed a hire date of [DATE]. The file included a completed Orientation checklist which included competencies for nursing responsibilities during cardiac arrest, verbalize the policy for Do Not Resuscitate (DNR) orders/Advanced Directives, use of airways, Ambu bags, checking the crash cart, and a valid CPR certification. Review of the employee file for CNA B revealed a hire date of [DATE]. CNA B was not CPR certified. Review of the employee file for CNA C revealed a hire date of [DATE]. CNA C was not CPR certified. 16. Review of the (Named County) Emergency Medical Services report dated [DATE], revealed a 911 call was received on [DATE] at 6:17:58 AM and Resident #1 was noted to be dead without resuscitation efforts and was pronounced dead at 6:30 AM. Resident #1 had significant lividity in the head and neck core, extremities were cold to touch and the Resident's jaw had rigor mortis (temporary stiffening of the joints and muscles that usually begins in the face/jaw within 2 to 4 hours after death). Review of the County Emergency Communications dated [DATE], revealed a call was made at 6:17:58 by LPN A, EMS was assigned at 6:19:13 AM, and the Fire Station was assigned at 6:20:32 AM. The Fire Department arrived on scene at 6:24:06 AM, Medic arrived at 6:25:50 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	AM, EMS Battalion Chief arrived at 6:29:28 AM, and the police department arrived at 6:36:48. 17. Review of the QAPI Committee Meeting Minutes dated [DATE], revealed the Code Blue Policy, Allegations of Compliance (AOC), Performance Improvement Plan (PIP), Resident (#1's) Code Status and Process, Staff Education Inservice (begun [DATE]), and Mock Code Drills were discussed. The Quality Performance/Peer Review Facility Plan of Action/Continuous Quality Improvement revealed on [DATE] LPN A was educated and counseled on BLS Standards, CPR Policy, and Facility Expectations during Code Blue Response, on [DATE] a Mock Code Blue Scenario with Administrator and DON present was observed and an audit was conducted of employee files by Regional Human Resources of LPN and Certified Nurse Assistants who were certified with CPR. The facility failed to administer continuous CPR for a full-code resident who was found not breathing and without a pulse. 18. During an interview on [DATE] at 10:00 AM, the Nurse Practitioner was asked was she aware of the event that occurred involving Resident #1. When asked what she had been made aware of, she responded she was told that the facility had provided CPR. When asked what should be done when a resident with a Full-Code status was found without vital signs, she stated, .CPR should be performed . and verified the .resident should not be left alone by the staff after found . The NP was asked whether CPR should be discontinued once initiated prior to the arrival of EMS. The NP stated .EMS usually responds pretty quickly so staff has to do the best that they can until EMS arrives . During a telephone interview on [DATE] at 3:02 PM, Family Member (FM) D confirmed she was told by the facility that CPR was started and performed until EMS arrived at the facility. During an interview on [DATE] at 3:30 PM, FM D and FM E provided this surveyor with large files via airdrop (transfer of photos, videos, or documents between devices of a certain type). FM D and E stated Resident #1 had been treated for cirrhosis (advanced, irreversible liver scarring caused be chronic diseases such as hepatitis or alcohol abuse) for the past 2 years, had been placed on the transplant list, and had a Model for End-Stage Liver Disease (MELD) score of 13 (Numerical score used to assess the severity of chronic liver disease. Less than 15 indicates stable condition). FM D and FM E stated they had ordered an autopsy. During a phone interview on [DATE] at 8:15 PM CNA B said that she was Resident #1's CNA on the night of [DATE]. CNA B said she had made her 4 o'clock rounds and Resident #1 was lying in the bed and complained that he was not feeling well. She said that she gave him a basin in case he needed to vomit, his urinal and instructed him to call out if he needed any assistance. She said she went down to Resident #1's room when she noticed the call light was on and his roommate said that Resident #1 had been in the bathroom for a long time. The bathroom door was closed so she knocked on the door and there was no answer. When CNA B went into the bathroom, she noticed that Resident #1 was on his knees and did not respond. CNA B said she did not touch Resident #1 and went to get the nurse. She was asked whether she participated in CPR and she verified that she did not and did not see the nurse nor the emergency medical staff do CPR. CNA C was called four times requesting an interview, and she did not return any of the calls. During a telephone interview on [DATE] at 7:25 AM, LPN A was asked to explain what she saw once she entered Resident #1's room. LPN A stated, .He [Resident #1] was slumped over. He was in the bathroom.horizontal over the toilet . When asked to describe what she means by 'slumped over', LPN A stated he had .knees on the ground, slumped over.horizontally. LPN A was asked if he appeared like he was going to vomit. LPN A responded, .that's what it appeared but when we was [were] yelling his name and everything and then I looked at the floor and it [there] was blood down there.he was not responding and there was blood on the floor so I called 911.When I pulled him off of it [the toilet] though, he was blue.when I pulled him off to try to do CPR.he was blue.he was still of course not responding, and he was cold to touch. LPN A was asked when she went in Resident #1's room for the first time was Resident #1 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	breathing and did he have a pulse. LPN A responded, No. He wasn't, He wasn't responding when I first went in there and I seen [saw] the blood.and when I pulled him off.he still wasn't responding, he wasn't breathing, he still didn't have a pulse.when I seen [saw] him, his eye was bloodshot red . LPN A was asked the reason CPR was not done and she responded, he was already cold to touch and when I was on the phone with 911 to see if they still wanted me to initiate.they was like EMS was already in the building and just relay that to them.they were literally coming down the hallway. LPN A was asked if the facility has an Automated External Device (AED) and she said they did have a AED which was kept on the crash cart . LPN A was asked if she hooked the AED machine up to Resident #1. LPN A stated, .No, it wasn't no point to hook it up to him. LPN A was asked where the other nurse on the shift was located and whether she assisted with the code. LPN A responded, .it was just me and then two techs.I called a code blue and could not stop to try and locate the other nurse . During a phone interview on [DATE] at 2:59 PM, LPN G was asked whether she was aware of the Code Blue and she said she was not aware there was a Code Blue called at the facility. During an interview on [DATE] at 9:45 AM, the Regional Director of Operations and the [NAME] President of Clinical were asked when LPN A went into the room after she was notified of Resident #1 being unresponsive and how long she was in the room. The Regional Director of Operation said LPN A went in the room (Resident #1's room) immediately after she (LPN A) was made aware and stated, .she [LPN A] was in the room [Resident #1's room] approximately 11 seconds . When asked if that was enough time to do a proper assessment, the Regional Director of Operations agreed that 11 seconds were not long enough time to do a proper assessment, and the [NAME] President of Clinical nodded her head as if she agreed. During an interview on [DATE] at 12:20 PM, the DON was asked whether there should be documentation regarding the reason for as needed (PRN) medications and whether the effectiveness should be documented. The DON said the effectiveness should be documented in a progress note. The DON was asked the reason for the education of LPN A and the initiation of Mock Code Drills. The DON responded, .they were started because of the delay in CPR [on [DATE]].I was always taught that if a resident was a full code and did not have an Advanced Directive.CPR should automatically be initiated. The DON was asked which CPR policy did the facility follow. The DON confirmed she would need to follow up with the Administrator who later confirmed the facility utilized both the facility policy and the American Heart Association [AHA] guidelines. The facility policy has since been revised to reflect the AHA guidelines which allows CPR not to be performed on a resident with a full-code status if there are signs of irreversible death to include rigor mortis (temporary stiffening of muscles after death), dependent lividity (purple red discoloration of the skin cause by blood settling), decapitation (cutting off of the head), transection (cutting across a structure) and decomposition (break down of the body). During an interview on [DATE] at 4:00 PM, the Administrator said, he implemented Mock Code Drills due to the family dynamic that was displayed at the time of death. After review of the facility's plan of action, the Administrator was asked why he and the DON were educated. The Administrator responded, .corporate educated us [the Administrator and the DON] due to the changes in the policy related to Lividity.only a Registered Nurse [RN] can assess for lividity.based on the company's policy, state regulations and the American Heart Association. An acceptable Removal Plan which removed the immediacy of the Jeopardy was received on [DATE] at 12:15 PM and was validated onsite by the surveyor through medical record review, in-service sign-in log review, audit/monitoring tool review, and interviews. AOC #2 Facility: Waters of [NAME] Removal of Immediacy or IJ F-678 cited [DATE] As required by state and federal law, the facility, the Waters of [NAME], is respectively submitting the following removal of immediacy in order to request removal of the Immediate Jeopardy. Disclaimer Statement: The completion and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445480	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waters of Springfield LLC	704 5th Avenue East Springfield, TN 37172

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	submission of the credible allegation of compliance does not constitute an admission that the facility agrees with the allegation in the notification of Immediate Jeopardy. The facility is completing the removal of immediacy because it is required by state and federal law. The facility disagrees with and disputes the alleged deficiency as stated in the notification and disagrees with the accuracy of statements and other information relied upon in the support of the alleged deficiencies. This includes but is not limited to the alleged content/summary of interviews, the chronological training sequence of events and contact with healthcare professionals, and the description of the care and supervision provided to resident(s). The facility reserves its right to continue disputing, appealing and contesting this alleged deficiency and any action related to or arising therefrom in any other forum as needed. Allegation---F-678-Cardio-Pulmonary Resuscitation (CPR)-Basic Life Support The facility failed to provide continuous BLS (basic life support)/Cardiopulmonary Resuscitation (CPR) to a vulnerable resident, who was found on [DATE] at 6:07 AM, in the bathroom, on his knees slumped over the commode unresponsive. The facility failed to provide continuous CPR until local Emergency Medical services arrived, took over, and / or pronounced the resident deceased . Resident(s) Affected- As stated prior, Resident #1 expired. How other residents having the same potential to be affected by the same deficient practice will be identified, and what corrective action(s) will be taken- Residents who reside in the facility have the potential to be affected by this finding. Administrator and DON educated on BLS Standards, CPR Policy, and Facility Expectations during a Code Blue Response by the Regional Nurse on [DATE] to include: GUIDELINES FOR CARDIOPULMONARY RESUSCITATION-CPR Intent: It is the intent of the facility to ensure that it is able to-and does---provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physician orders, such as DNR (Do Not Resuscitate) as well as a resident's personal Advance D