STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER: Dayton Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 310 E Lawrence St Dayton, TX 77535	

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** 32217 Based on observations, interviews, and record reviews, the facility failed to provide basic life support, including CPR to a resident requiring such emergency care and subject to related physician orders and the resident's advance directives for 1 (Resident #1) of 31 residents reviewed for CPR. Resident #1 was found unresponsive on [DATE] around 4:00 a.m. by CNA B who immediately notified LVN A. LVN A failed to verify Resident #1's code status before calling hospice which led to the resident being pronounced dead and CPR not being initiated for approximately 2.5 hours after the resident was found to be unresponsive. The facility did not immediately provide CPR and call 911 for Resident #1 who was a full code (wanted all possible life saving measures in the event his heart or breathing stopped) when the resident was found unresponsive by CNA B. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before survey began. This failure could place residents at risk of not receiving life saving measures including CPR and could lead to death. Findings included: Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebrovascular disease, pneumonia, and anoxic brain damage. (Brain was deprived of oxygen causing brain cells to die) Record review of Resident #1's significant change MDS dated [DATE] indicated he had a BIMS score of 11 out of 15, which indicated his cognition was moderately impaired. Record review of Resident #1's care plan dated [DATE], indicated Resident #1 had code status as Full Code. Interventions included advanced directives will be kept in chart. If resident was found with no pulse and/or respirations, notify physician, EMT's, and begin CPR. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Dayton Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 310 E Lawrence St Dayton, TX 77535	

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	Record review of Resident #1's progress notes dated [DATE] at 4:15 a.m., documented by LVN A stated Resident was found with no signs of life, Hospice notified, and stated they would be here as soon as she can. Stated she will call family and funeral home. Message left for ADON. During an interview on [DATE] at 12:15 p.m., CNA B said she had been employed at facility since February 2024. She said she received orientation including Abuse/Neglect. She said she took the CPR class offered at the facility on [DATE]. She said staff knew of the resident's code statuses in the computer next to their name. CNA B said there was also a binder on the crash cart with every resident's code status and paperwork. She said she made rounds on residents about every ,d+[DATE] hours. She said on [DATE] while working her shift, she saw Resident #1 around 2:30 a.m., and he was fine. She said on her next rounding at 4:00 a.m., he was unresponsive. She said his lips were white and his nailbeds were blue/purple, and his body was warm to the touch. She said she yelled for the nurse. She said the nurse went and looked at him and went back to the nurse's station. CNA B said she told the nurse she thought the resident was a full code. She said LVN A threw her hands up in the air and told her the resident was a hospice patient and there was not anything she could do for him. CNA B said she told the nurse she should do something, and the nurse told her he was already gone, and it was too late. CNA B said the nurse did not start CPR or use the AED while she was in facility. CNA B said postmortem care was performed. CNA B said when her shift was over at 6:00 a.m., the resident was still in facility and the LVN A had done nothing. During a phone interview on [DATE] at 2:09 p.m., LVN A said on [DATE] at approximately 4:00 a.m., CNA B summoned her to Resident #1's room. LVN A said when she entered his room, Resident #1's face looked like candle wax. She said he had no pulse, heartbeat, or respirations. LVN A said they turned him, and he had rigor mortis (rigor mortis-stiffening of the joints and muscles of a body a few hours after death). Next, she called the hospice agency at 4:15 a.m. and informed the service of his death. She said the hospice on-call nurse returned her call and told her it would take about 1.5 hours for her to arrive. LVN A said after she hung up with the hospice nurse, she then went about her duties and prepared medications that were due before the end of her shift for other residents. She said when the hospice nurse arrived at 6:30 a.m., the hospice nurse told her the resident was a full code. LVN A said the hospice nurse said she could not pronounce the resident as deceased because he was a full code and CPR or EMS had not been activated. LVN A said she clocked out of her shift and was on her way home when LVN D phoned her to return to the facility. LVN A said after returning to facility, she initiated CPR and hooked up the AED to Resident #1. This was approximately 2.5 hours after finding Resident #1 unresponsive. She said EMS arrived and pronounced Resident #1 dead. She stated, I did not know he was a full code and how can they be with hospice? She added It is fully my fault. I did not check his code status. I knew where to look but it never crossed my mind. She stated I was worried about getting my work done. People are getting fired left and right around here. She said she had been a nurse since 1985 and had done CPR in the past but never on a hospice patient. Record Review of a hospice note for Resident #1's incident indicated the hospice RN arrived at the facility on [DATE] at 6:36 a.m. She noted receiving a call from the hospice answering service that LVN A had reported Resident #1 expired. The hospice RN returned the call to the facility and gave her an estimated time of arrival. Upon arrival to facility, learned that EMS had not been called and no CPR initiated. Pt. was a full code. Informed LVN that EMS needed to be called and CPR initiated. Ambulance service responded and took over from LVN who was doing CPR at bedside. They pronounced patient at 7:32 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Dayton Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 310 E Lawrence St Dayton, TX 77535	

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	During a phone interview on [DATE] at 1:00 p.m., the Hospice RN said she received a message through the hospice answering service that Resident #1 had expired. She said when she arrived at the facility around 6:30 a.m., she opened her computer and saw that the resident was a full code. She asked the facility staff about CPR or calling 911. She said LVN A told her there was a note on his chart saying not to send out to the hospital and this was the reason she did not initiate CPR. She said apparently the nurse exited the facility after her shift and the hospice RN told them to get her back to finish up with the resident. She said LVN A returned and initiated CPR and another staff called EMS. She said she could not pronounce because the resident had been a full code and CPR had not been initiated until after she arrived and was made aware. During an interview on [DATE] at 9:30 a.m., the Administrator said she was notified by MA C of the situation with Resident #1 at approximately 6:30 a.m. She said LVN A said she believed she did nothing wrong because the resident was a hospice patient. The Administrator said LVN A told her the resident was cold to the touch when she found him. She said the nurse called hospice and was told by the hospice nurse that she must do something because the resident was a full code. She was told to call EMS by the hospice nurse. The Administrator said the on-call hospice nurse came to the facility and would not pronounce this resident because the facility nurse had not initiated CPR. She said finally LVN A called EMS and began CPR when she returned to facility approximately within 10 minutes of leaving the facility. The spouse was also called and came to facility. The Administrator said LVN A had not been employed at the facility for a long amount of time and had been a nurse for over [AGE] years. She said LVN A was CPR certified. The Administrator said LVN A was suspended pending investigation, and on the next day, had phoned to see when she could come back to work. She said LVN A seemed to believe she had done nothing wrong and wanted to return to work. She said all nurses currently were CPR certified and a CPR class was held on Friday after the incident (occurred on Wednesday). She said she held mock codes on Friday and one on Saturday for the staff due to the incident. Her expectations were for all staff to be knowledgeable of the code process and to feel comfortable performing CPR on residents should the occasion arise. Any direct care staff not current on CPR were not allowed to work on floor until current. Following a facility investigation, LVN A was terminated from facility on [DATE]. During an interview at on [DATE] at 12:50 p.m., MA C said she started working at the facility in [DATE]. She said she had attended CPR class offered by the facility following this incident. She said there was a binder on top of the crash cart at the nurses' station which contained all information of the residents' code statuses. She added staff could also look in the computer. She said when she arrived at the facility for her shift, LVN A told her Resident #1 had passed away. She said LVN A told her she had left a message for the DON but had not informed the administrator of resident's death. She said she called the administrator to inform her, and that the administrator was unaware of death at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Dayton Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 310 E Lawrence St Dayton, TX 77535	

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	During an interview on [DATE] at 1:40 p.m., the DON said she received a text from the Administrator at 7:00 a.m. informing her of Resident #1 passing away and CPR had not been initiated. She said she arrived at the facility at 8:15 a.m. She said when the nurse for the day shift arrived for her shift at 6:00 a.m., the hospice nurse was freaking out because no one had initiated CPR on Resident #1 and that someone should call EMS/911. The DON said LVN A told her the resident was a hospice patient and the DON told her she still had to do CPR. The DON said LVN A had not informed the resident's physician, the DON, or Administrator of the incident prior to their arrival. The DON said the resident's medical record indicated what specific hospital Resident #1's spouse did not want the resident sent to, but there were other hospital facilities available. She said LVN A knew the resident was a full code. She added how could you be a nurse for [AGE] years, or 4 days, and not know you have to do CPR? To ensure all staff received the trainings, she said a CPR audit was conducted on all direct care staff. Any direct care staff not current on CPR were not allowed to work on floor until current. Mock codes utilized a CPR dummy and there was return demonstration. DON/designee will perform monthly audit of direct care staff to ensure all were current on CPR. Current CPR certification will be verified on all new hires of direct care staff. Will perform random mock codes. During a phone interview on [DATE] at 2:00 p.m., LVN D said she worked the day shift. She said during report on [DATE] at 6:00 a.m., she was informed Resident #1 had expired. She said the hospice RN arrived around 6:30 a.m. and started asking questions about the resident such as, had CPR been initiated and had first responders been notified. LVN D said she told the hospice nurse that all she had been told was that the resident had passed. She said the hospice nurse wanted LVN A to come back to facility, so she called her to return. She said after LVN A and the hospice RN spoke, LVN A called EMS and went to the room to initiate CPR. LVN D said she had been a nurse for [AGE] years and had been at the facility for about one month. She was able to explain code status and response with the state surveyor. During interview on [DATE] at 11:00 a.m., the ADON said LVN A called her about 4:30 a.m. on [DATE] but she did not hear her phone. She said later that morning, when she listened to the voicemail, the message was to inform her of Resident #1 passing. She was not aware of the situation until she arrived at the facility around 7:30 a.m . Reviewed crash cart and AED documents on [DATE] at 11:15 a.m. The crash cart had a binder with a list of every resident's code status with copies of advance directives and out-of-hospital DNRs. Residents with full codes had green sheets with their name and room number in big, bold letters. On [DATE] at 4:00 p.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before survey began. The facility implemented the following interventions: -Immediate suspension of LVN A -CPR audit conducted on all direct care staff -Abuse/Neglect in-service -in-service on emergency procedures for codes (CPR) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Dayton Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 310 E Lawrence St Dayton, TX 77535	

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	-Performed 3 mock codes with more planned -held CPR training recertification class These interventions were verified by state surveyor. Review of Provider Investigation Report dated [DATE] indicated the following: *Provider Response - Nurse was immediately suspended pending investigation. Family, physician, NP and local law enforcement notified. Facility wide re-educationinitiated. *Investigation Summary - Nurse did not initiate CPR or call 911 to a full code hospice resident when she found him with no signs of life at 4:15 a.m. *Investigation Findings - confirmed *Provider Action Taken Post - Investigation - Nurse suspended pending investigation. In-service on code status, neglect and proper reporting procedures initiated. Facility verified that all direct care staff has current CPR certification. Mock codes initiated for all shifts. CPR class provided. Record review of training held on [DATE] indicated facility held an in-service on General Abuse and Neglect for all Nursing staff. There were 35 staff members who attended. Record review of training held on [DATE] indicated facility held an in-service on Emergency Procedure for Codes and Documentation. There were 21 in attendance. Record review of training held on [DATE] indicated facility held training on CPR and First Aid and AED. There were 10 direct care staff who updated their CPR cards by recertification. Record review of training for Mock Code - with education on code status emergency response provided held on [DATE] with 4 nursing staff participating. Record review of training for Mock Code - with education on code status emergency response provided held on [DATE] with 4 nursing staff, a housekeeper and a therapy person participating. Record review of training for Mock Code - with education on code status emergency response provided held on [DATE] with 6 nursing staff participating. During interviews on [DATE] from 11:00 a.m. through 4:30 p.m., 3 CNAs (CNA B, CNA G, and CNA H) were able to identify abuse/neglect, were knowledgeable of resident code status, and knew where to locate information of new resident's code status. They were aware of expectations to begin CPR immediately if resident was found unresponsive and was a full code. Each had engaged in the mock code drills performed following this incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dayton Nursing and Rehabilitation	310 E Lawrence St Dayton, TX 77535

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	During interviews on [DATE] from 11:00 a.m. through 4:30 p.m., 1 LVN (LVN D) and 3 MAs (MA C, MA E, and MA F) were able to identify abuse/neglect, were knowledgeable of resident code status, and knew where to locate information of new resident's code status. They were aware of expectations to begin CPR immediately if resident was found unresponsive and was a full code. Each had engaged in the mock code drills performed following this incident. During interviews on [DATE] from 11:00 a.m. through 4:30 p.m., the DON, the ADON, the RN supervisor, and Maintenance supervisor were able to identify abuse/neglect, were knowledgeable of resident code status, and knew where to locate information of new resident's code status. They were aware of expectations to begin CPR immediately if resident was found unresponsive and was a full code. Each had engaged in the mock code drills performed following this incident. Record review of an Emergency Procedure - Cardiopulmonary Resuscitation policy dated February 2018 indicated: . Personnel have completed training on the initiation of Cardiopulmonary Resuscitation (CPR) and basic life support, including defibrillation, for victims of sudden cardiac arrest. General Guidelines 6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR shall initiate CPR unless: a) it is known that a Do Not Resuscitate order that specifically prohibits CPR and/or external defibrillation exists for that individual or b) there are obvious signs of irreversible death. 7. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before survey began.