

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER Puget Sound Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 South 224th Street, Des Moines, WA 98198	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their abuse prohibition policy for 1 of 2 residents (Resident 1) reviewed for abuse and/or neglect. The failure to report to the appropriate agencies as required by State and Federal laws regarding Resident 1's unexpected death placed residents at risk for exposure to potential abuse/neglect, unmet care needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility policy titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised [DATE], showed if there was an allegation or suspicion of abuse, the facility would make a report to the appropriate agencies including the State Survey Agency (SSA). The policy showed if the event(s) that caused the allegation resulted in serious bodily injury, the reporting requirement was to immediately report the incident, no later than two hours from the incident. The policy included the results of the investigation must be reported to the appropriate agencies within five working days of the incident.</p> <p>&lt;Resident 1&gt;</p> <p>According to the [DATE] admission Minimum Data Set (MDS - an assessment tool), Resident 1 admitted to the facility on [DATE] and had medical conditions including heart disease. A [DATE] Death in Facility MDS showed Resident 1 expired.</p> <p>Review of Resident 1's medical records showed a [DATE] physician note indicating the resident was found dead unexpectedly.</p> <p>On [DATE] at 9:12 AM, Resident 1's representative stated the resident was at the facility for short-term rehabilitation and therapy due to generalized weakness and deconditioning after undergoing a heart procedure at the hospital. The representative stated Resident 1's goal was to eventually discharge back home.</p> <p>Review of the facility's [DATE] Incident Log showed Resident 1's unexpected death was not reported to the SSA, or a facility investigation was completed.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 1:17 PM, Staff A (Administrator) stated they were not aware Resident 1's unexpected death was not reported to the SSA as required because it was Staff B (Director of Nursing) who handled the incident.</p> <p>In an interview on [DATE] at 2:10 PM, Staff B stated they did not report Resident 1's unexpected death to the SSA because they did not know Resident 1's death was considered unexpected. Staff B stated they should have reported Resident 1's death to the SSA, but they did not.</p> <p>In an interview on [DATE] at 3:44 PM, Staff H (Corporate Clinical Resource) stated they referred to the Nursing Home (NH) Guidelines (also known as the Purple Book) in reporting facility incidents. Review of the Appendix D of the NH guidelines provided by Staff H outlined that an unexpected death must be reported to the SSA Hotline, SSA Log (within five days), Police or 911, and the coroner (a public official whose primary duty was to investigate deaths, particularly those that were violent, unexpected, or suspicious, to determine the cause and manner of death) or Medical Examiner.</p> <p>In an interview on [DATE] at 4:20 PM, Staff A stated Resident 1's unexpected death should have, but was not reported to the SSA as required.</p> <p>Refer to F610 - Investigate/Prevent/Correct Alleged Violation.</p> <p>Refer to F678- Cardiopulmonary Resuscitation.</p> <p>REFERENCE: WAC 399-97-0640(5)(a).</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their abuse prohibition policy for 1 of 2 residents (Resident 1) reviewed for abuse and/or neglect. The facility failed to completely and thoroughly investigate Resident 1's unexpected death. The failure to initiate, conduct a thorough investigation, and correct actual or potential alleged violations left residents at risk for unidentified and/or repeated incidents of abuse/neglect and a decreased quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility policy titled, Abuse: Prevention of and Prohibition Against, revised [DATE], showed all allegations of abuse, neglect, misappropriation of resident property and exploitation would be promptly and thoroughly investigated by the Administrator or their designee. The policy showed the investigation would include information obtained from interviews with the person(s) reporting the incident, residents, witnesses, and staff across all shifts. The policy showed a review of the resident's medical records and of all circumstances surrounding the incident would be included in the investigation. The policy showed, at the conclusion of the investigation, the facility would attempt to determine if abuse, neglect, misappropriation, or exploitation occurred. The policy showed the investigation, and the results of the investigation, would be documented.</p> <p>&lt;Resident 1&gt;</p> <p>According to the [DATE] admission Minimum Data Set (MDS - an assessment tool), Resident 1 admitted to the facility on [DATE] and had medical conditions including heart disease. A [DATE] Death in Facility MDS showed Resident 1 expired.</p> <p>On [DATE] at 9:12 AM, Resident 1's representative stated the resident was at the facility for short-term rehabilitation and therapy due to generalized weakness and deconditioning after undergoing a heart procedure at the hospital. The representative stated Resident 1's goal was to eventually discharge back home.</p> <p>The [DATE] Discharge care plan showed Resident 's goal was to return/be discharged to their home.</p> <p>Review of Resident 1's medical records showed a [DATE] physician note indicating the resident was found dead unexpectedly.</p> <p>Review of the facility's [DATE] Incident Log showed a facility incident investigation was not completed for Resident 1's unexpected death in the facility. When asked if there was any facility documentation to support Resident 1's unexpected death was investigated to rule out abuse/neglect, the facility provided a one-page, undated timeline of the events surrounding the death of Resident 1.</p> <p>In an interview on [DATE] at 1:17 PM, Staff A (Administrator) stated they were not aware Resident 1's unexpected death was not investigated by their designee.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 2:10 PM, Staff B (Director of Nursing) stated they did not investigate Resident 1's unexpected death because they did not know the resident's death was considered unexpected. Staff B stated they should have investigated Resident 1's death, but they did not.</p> <p>In an interview on [DATE] at 3:44 PM, Staff H (Corporate Clinical Resource) stated there were staff interviews conducted regarding Resident 1's death, but they were not documented in the resident's medical records.</p> <p>In an interview on [DATE] at 4:20 PM, Staff A stated Resident 1's unexpected death required a complete and thorough investigation to determine if abuse/neglect occurred or was ruled out. Staff A stated it was important to conduct incident investigations to determine failed practice existed and a plan to correct the failed practice was implemented.</p> <p>Refer to F609 - Reporting of Alleged Violations.</p> <p>Refer to F678- Cardiopulmonary Resuscitation.</p> <p>REFERENCE: WAC 399-97-0640(6)(a)(b).</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Basic Life Support (BLS) was initiated immediately, as directed in the facility policy, including Cardio-Pulmonary Resuscitation (CPR - an emergency procedure consisting of chest compressions combined with giving breaths of air) for 1 of 1 resident (Resident 1) reviewed for unexpected death in the facility. This failed practice placed 48 additional residents (Residents 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50 & 51), who had current physician orders to receive CPR, at serious risk for adverse outcome including death and constituted an Immediate Jeopardy (IJ).</p> <p>On [DATE] at 2:05 PM, the facility was notified of an IJ in F678. The facility removed the immediacy on [DATE] after they audited the records of all residents, audited the Physician Order for Life Sustaining Treatment (POLST - a form indicating the resident's wishes to have or not have CPR) binders, educated staff on the facility's Medical Emergency Response Policy for CPR, performed CPR drills and staff competency training, and implemented a plan of correction to sustain ongoing compliance.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of the facility policy, Cardiopulmonary Resuscitation, revised 04/2025, showed the facility would provide basic life support, including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel. The policy showed when a resident was found unresponsive, not breathing, and no pulse, the staff must activate the Emergency Medical Services (EMS) system, start CPR, and to not stop providing CPR until another trained responder or EMS personnel takes over. The policy showed the facility referred to the American Heart Association for guidelines.</p> <p>Review of the 2020 American Heart Association Advanced Cardiovascular Life Support Provider Manual showed the passage of time drove all aspects of emergency cardiovascular care. The guidance showed the final outcomes were determined by the intervals between collapse or onset of the emergency and the delivery of basic and advanced interventions, and that the probability of survival declined sharply with each passing minute of cardiopulmonary compromise.</p> <p>Review of the facility policy titled, Emergency Procedure - CPR, revised [DATE], showed key clinical staff members, who would direct resuscitative efforts, must obtain and/or maintain their American Red Cross or American Heart Association certification in BLS/CPR, and had completed training on the initiation of BLS/CPR, including the use of an Automated External Defibrillator (AED - a device that analyzes the heart's rhythm and can deliver an electric shock in cases of sudden cardiac arrest). The policy showed the licensed staff member, who was certified in CPR, should initiate CPR unless a Do Not Resuscitate order was in place or there were obvious signs of irreversible death such as rigor mortis (the stiffening of muscles that occurs after death due to chemical changes in the muscle tissue).</p> <p>&lt;Resident 1&gt;</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>According to the [DATE] admission Minimum Data Set (MDS - an assessment tool), Resident 1 admitted to the facility on [DATE] and had medical conditions including heart disease. A [DATE] Death in Facility entry in the MDS showed Resident 1 had expired.</p> <p>Review of Resident 1's POLST showed it was signed by the resident on [DATE] and signed by the Physician's Assistant on [DATE]. The form showed Resident 1 wanted CPR if they were not breathing and had no pulse. The form showed Resident 1 wanted full treatment to prolong life by all medically effective means including transfer to the hospital and intensive care (Full Code).</p> <p>Review of Resident 1's electronic medical record showed Resident 1 was designated as a Full Code under their physician's orders.</p> <p>Review of a [DATE] nursing progress note showed, at 3:20 PM, Staff C (Registered Nurse) found Resident 1 sitting on the wheelchair with their head down, unresponsive without a pulse and was not breathing. The note showed Staff C performed a sternal rub (a technique to test an unconscious person's responsiveness) and when Resident 1 did not respond, Staff C left the resident to call and notify the Director of Nursing (DON).</p> <p>Review of the undated incident timeline provided by Staff B (DON) showed on [DATE] at 3:20 PM, Staff C found Resident 1 unresponsive, without a pulse, and was not breathing. At 3:23 PM, Staff B came to Resident 1's room with the physician assistant and asked Staff C why CPR was not being performed for Resident 1. At 3:25 PM, Resident 1 was pronounced deceased by the physician assistant.</p> <p>Review of Resident 1's medical records showed CPR was not performed and 911/EMS was not called to respond.</p> <p>In an interview on [DATE] at 2:10 PM, Staff B stated Resident 1 elected a Full Code status. Staff B stated CPR should have been initiated for Resident 1 after they were found unresponsive, without a pulse and not breathing by Staff C, who was first on the scene, but did not.</p> <p>In an interview on [DATE] at 2:37 PM, Staff C stated they were the first licensed staff on the scene to find Resident 1 unresponsive, without a pulse, and was not breathing. Staff C stated they did not activate the EMS or assess Resident 1 for obvious signs of irreversible death because they panicked, .I [nurse] got nervous, so I called the DON instead. Staff C stated they should have initiated CPR on Resident 1 when they initially found the resident but did not. Staff C stated Staff's D & E (Certified Nursing Assistants) were with them in Resident 1's room while waiting for the DON to arrive.</p> <p>Review of Staff C's CPR card showed it was renewed on [DATE]. Review of Staff D's CPR card showed it expired last [DATE] and was not current at the time of the incident on [DATE]. Review of Staff E's CPR card showed it expired [DATE] and was not current at the time of the incident on [DATE].</p> <p>In an interview on [DATE] at 2:27 PM, Staff A (Administrator) stated the facility did not have a process in place that ensured the staff's CPR cards were current or reviewed before they expired.</p> <p>In a joint interview with Staff A and Staff B on [DATE] at 4:57 PM, Staff A stated they expected all licensed staff who were trained in CPR to perform CPR on Full Code residents. Staff A stated performing CPR was a critical element in saving a resident's life during an emergency.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the electronic medical records showed 48 residents (Residents 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50 & 51) had current physician orders to receive CPR according to the facility policy. These 48 residents all resided in the facility on [DATE].</p> <p>Refer to F609 - Reporting of Alleged Violations.</p> <p>Refer to F610 - Investigate/Prevent/Correct Alleged Violation.</p> <p>Refer to F726 - Competent Nursing Staff.</p> <p>REFERENCE: WAC 388-97-1060(1).</p> <p>.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 3 of 7 staff (Staff C, D, & E) reviewed and 1 supplemental staff (Staff F) had the appropriate knowledge, competencies, and skill sets to provide nursing and related services, including Cardio-Pulmonary Resuscitation (CPR - an emergency procedure consisting of chest compressions combined with giving breaths of air), to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments, individual plans of care, and the facility assessment. Failure of the nursing staff to demonstrate a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics needed to successfully perform work roles or occupational functions resulted in deficiencies related to the competency of nursing staff and placed residents at risk for unmet care needs including not receiving CPR if/when needed, a diminished quality of life, and adverse outcomes including death.</p> <p>Findings included .</p> <p>&lt;Facility Assessment&gt;</p> <p>The 2025 Facility Assessment showed the facility must conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. The assessment outlined processes and methods to ensure staff competencies. The assessment showed the facility required all licensed nurses (Registered Nurse - RN/ Licensed Practical Nurse - LPN and Certified Nursing Assistant - CNA) to achieve and maintain a current Healthcare Provider CPR verification.</p> <p>&lt;Staff C&gt;</p> <p>Review of Staff C's Learning Management System (LMS) records showed the staff had no education and/or training regarding the facility's Emergency Response procedures including CPR.</p> <p>In an interview on [DATE] at 2:37 PM, Staff C stated they did not provide CPR to a resident whom they found unresponsive, without a pulse, and was not breathing, as required because they panicked and did not know what to do.</p> <p>In an interview on [DATE] at 4:57 PM, Staff B (Director of Nursing) reviewed the LMS training records list and stated there were no Emergency Response procedures regarding CPR or Code Blue (an emergency code, typically indicating a patient was experiencing a life-threatening cardiac or respiratory arrest) completed by staff, .the training needs to be assigned to them first in the LMS. Staff B stated it was important to ensure the facility provided the staff with education and training in Emergency Response procedures so that they were competent in performing proper CPR during an emergency.</p> <p>&lt;Staff D&gt;</p> <p>Review of Staff D's (CNA) CPR card showed it expired last [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Staff D's LMS records showed the staff had no education and/or training regarding the facility's Emergency Response procedures including CPR.</p> <p>In an interview on [DATE] at 1:07 PM, Staff D stated they were present with Staff C in the room where a resident was found unresponsive, without a pulse, and was not breathing. Staff D stated they did not perform CPR as required.</p> <p>&lt;Staff E&gt;</p> <p>Review of Staff E's (CNA) CPR card showed it expired last [DATE].</p> <p>Review of Staff E's LMS records showed the staff had no education and/or training regarding the facility's Emergency Response procedures including CPR.</p> <p>In an interview on [DATE] at 2:28 PM, Staff E stated they were present with Staff C in the room where a resident was found unresponsive, without a pulse, and was not breathing. Staff E stated they did not perform CPR because they expected the nurse to do it [CPR].</p> <p>&lt;Staff F&gt;</p> <p>Observation on [DATE] at 11:27 AM showed the facility's Automated External Defibrillator (AED - a device that analyzes the heart's rhythm and can deliver an electric shock in cases of sudden cardiac arrest) was located at the second floor nurse's station.</p> <p>Observation on [DATE] at 11:33 AM showed there was no AED located at the third floor nurse's station.</p> <p>In an observation and interview on [DATE] at 4:45 PM, Staff F (LPN), who was observed typing at the third floor nurse's station, was asked where the location on the facility's AED was. Staff F stated they did not know where the AED was located, I need to ask my supervisor where . When Staff F was asked if they should know the AED's location in case of an emergency, Staff F stated, Yes, I should.</p> <p>In an interview on [DATE] at 4:50 PM, Staff G (Resident Care Manager) stated there used to be an AED at the third floor nurse's station, but it broke down and was taken out for repair. Staff G stated the only functioning AED was the one located on the second floor nurse's station. When asked if they expected Staff F to know the AED's location, Staff F stated, Yes, most definitely .I expect everyone [all staff] here in the nursing unit to know where to get it [AED].</p> <p>Refer to F678 - Cardiopulmonary Resuscitation.</p> <p>REFERENCE: WAC 388-97-1080(1).</p>		