STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555030	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Vista Post-Acute	4681 Eagle Rock Blvd. Los Angeles, CA 90041

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 92) was treated in a dignified and respectful manner as demonstrated by failing to provide appropriate body coverage when Certified Nursing Assistant (CNA) 7 transported Resident 92 in the hallway to the shower room. This deficient practice had the potential to cause Resident 92 to be embarrassed and result in psychosocial (mental and emotional well-being) decline, resident ' s individuality, self-esteem, and self-worth. Findings: A review of Resident 92's Admission Record indicated Resident 92 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus without complications (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), hypokalemia (lower than normal potassium [a mineral and electrolyte, which conducts electrical impulses throughout the body] in the blood stream), and hyperlipidemia (high cholesterol, high levels of lipids (fat) in the blood). A review of Resident 92's History and Physical dated 5/3/2024 indicated Resident 92 had the capacity to understand and make decisions. During an observation and concurrent interview in the facility hallway near Shower room [ROOM NUMBER] on 5/4/2024 at 8:51 AM, Resident 92 was observed being transported via shower chair to the shower room by CNA 7. Resident 92's left, and right upper leg were not covered and exposed. The DON stated to the CNA to cover up Resident 92 when transporting the resident in the hallway to the shower room. During an interview with CNA 6 on 5/4/2024 at 1:31 PM, CNA 7 stated it was important for residents' body to be fully covered for their dignity and privacy. During an interview with the DON on 5/5/2024 at 7:52 PM, the DON stated the importance of making sure resident ' s body are fully covered was for dignity. The DON stated they do not want resident to feel exposed or uncomfortable. (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: 555030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled Promoting/Maintaining Resident Dignity, dated 12/19/2022 indicated all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of need for four of four sampled residents (Resident 17, 29, 31, and 34) by failing to ensure the resident's call light was within reach as indicated in the facility's policy and procedure and resident's care plan. This deficient practice had the potential for Resident 17, 29, 31, and 34) not to receive or received delayed care to meet necessary care and services that could result in fall and accident. Findings: 1. A review of Resident 34's Admission Record indicated an admission on 10/3/2023 with diagnoses of unspecified dementia (characterized by impairment of at least two brain functions, such as memory loss and judgment, symptoms include forgetfulness, limited social skills and thinking abilities so impaired that it interferes with daily functioning), Alzheimer ' s disease (progressive disease that destroys memory and other important mental functions), and abnormalities of gait (manner of walking) and mobility. A review of Resident 34's History and Physical assessment dated [DATE], indicated Resident 34 had fluctuating capacity to understand and make decisions. A review of Resident 34's Care plan dated 10/3/2023 indicated Resident 34 was at risk for falls related to gait/balance problems, incontinence, dementia and malnutrition. The care plan indicated to place Resident ' s call light within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview in Resident 34's room on 5/3/2024 at 6:59 PM, Resident 34's call light was observed behind the bed headboard and out of Resident 34 ' s reach. Resident 34 stated she did not know where her call light was located. During a concurrent observation and interview in Resident 34's room on 5/3/2024 at 7:06 PM, certified nursing assistant (CNA) 5 stated Resident 34's call light should be within her reach. CNA 5 stated the call light should be within reach so residents can call if they need assistance. CNA 5 stated it was important for the call light to be within residents reach to avoid accidents and falls. 2. A review of Resident 17's Admission Record indicated an admission on 1/3/2024 with diagnoses of metabolic encephalopathy (an alteration in consciousness caused due to brain dysfunction), parkinsonism (a motor syndrome that manifests as rigidity, tremors, and bradykinesia [slowness of movement and speed]) and unspecified dementia. A review of Resident 17's History and Physical assessment dated [DATE], indicated Resident 17 did not have the capacity to understand and make decisions. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 17's Care plan dated 1/11/2024 indicated Resident 17 was at risk for falls related to functional quadriplegia (paralysis of all four limbs) and dementia. The care plan indicated to place Resident ' s call light within reach and encourage the resident to use it for assistance as needed. During an observation in Resident 17's room on 5/3/2024 at 7:24 PM, Resident 17's call light was observed hanging off the left side of Resident 17 ' s bed and touching the floor, the call light was not within resident 17's reach. During a concurrent observation and interview in Resident 17 ' s room on 5/3/2024 at 7:28 PM, CNA 6 stated Resident 17's call light should be within her reach in case resident needs anything. The CNA 6 stated call lights are used by residents to alert staff if resident needed assistance and could aid in the prevention of accidents. During an interview with the Director of Nursing (DON) on 5/5/2024, the DON stated the purpose of the call light was for the residents to communicate their needs. The DON stated if the call light was not within resident ' s reach, the residents could be in distress, or could cause an accident like a fall. A review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, revised 12/22, indicated staff will ensure the call light is within reach of resident.The P&P also indicated the call system will be accessible to residents while in their bed. 48854 3. A review of Resident 29 Admission Records indicated Resident 29 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of Alzheimer ' s (a condition in brain that leads to memory loss, physical decline, and confusion) and encephalopathy (damage or disease that affects the brain). A review of Resident 29 ' s History and Physical (H&P), dated 10/17/23, indicated Resident 29 did not have the capacity to understand and make decisions. A review of Resident 29 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 4/5/23, indicated Resident 29 required touching assistance (helper provides verbal cues or touching) with activities of daily living, including bed mobility (how resident moves while in bed such as turning from side to side). The MDS also indicated Resident 29 had severe cognitive impairment. A review of Resident 29 ' s care plan for risk for falls, initiated on 10/17/23, and revised on 4/7/24, indicated for staff to place the resident ' s call light within reach and that Resident 29 needs prompt response to all requests for assistance. 4. A review of Resident 31 ' s Admission Records indicated Resident 31 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture) and weakness. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 31 ' s H&P, dated 3/28/24, indicate Resident 31 did not have the capacity to understand and make decisions. A review of Resident 31 ' s MDS, dated [DATE], indicated Resident 31 severe cognitive impairment. The MDS also indicated Resident 31 was dependent (helper does all of the effort) on staff for all activities of daily living such as eating, bathing, and bed mobility. A review of Resident 31 ' s care plan for risk for falls, initiated on 6/1/23, and revised on 4/5/24, indicated for staff to place the resident ' s call light is within reach and that Resident 31 needs prompt response to all requests for assistance. The care plan also indicated Resident 31 needs a safe environment with: reachable call light. During a concurrent observation and interview on 5/3/24 at 7:41 PM inside Resident 29 ' s room with Certified Nursing Assistant (CNA) 5, Resident 29 ' s call light was observed hanging from the left side of the bed and touching the floor. CNA 5 stated the call light was out of reach of Resident 29. CNA 5 stated the call light should be within reach of Resident 29 in order for Resident 29 to call staff for help and to prevent accidents. During a concurrent observation and interview on 5/3/24 at 8:10 PM inside Resident 31 ' s room with Licensed Vocational Nurse (LVN) 6, Resident 31 ' s call light was observed wrapped around Resident 31 ' s feeding pump. LVN 6 stated the call light was not within Resident 31 ' s reach. LVN 6 stated the call light should be within the resident ' s reach so residents could call for help when needed. LVN 6 stated if the call light was not within reach, the resident could be in danger of falling and not getting help. During an interview on 5/5/24 at 6:11 PM with the Director of Nursing (DON), the DON stated call lights must be kept within reach of the resident. The DON stated if residents do not have access to the call lights, they would not be able to call for help, and staff could not address the resident ' s needs. The DON stated when call lights were not witching reach, accidents such as resident falls could happen.

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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** 42878 Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 41) was immediately provided CPR (cardiopulmonary resuscitation a lifesaving emergency procedure for a victim who has signs of cardiac arrest [a situation when a victim becomes unresponsive, no normal breathing, and no pulse] consisting of a combination of chest compressions, mouth-to-mouth, or mechanical breathing [a device used to help someone breathe]) prior to the arrival of emergency medical personnel in accordance with the standard of practice and the facility's policy and procedure titled Medical Emergency Response and Cardiopulmonary Resuscitation (CPR) by failing to: 1. Ensure Licensed Vocational Nurse (LVN 1) immediately initiated CPR to Resident 41 when found unresponsive, without pulse and not breathing rather than checking the code status (a resident's record that describes the type of life saving procedures (if any) the resident or their representative would the health care team to conduct if your heart stopped beating and/or stopped breathing to keep him/her alive) of Resident 41 and calling for assistance. 2. Ensure Resident 41's Advance Directives (document signed by the resident or representative indicating the care treatments that the resident wished in an event of emergency) and or POLST (a Portable Orders for Life Sustaining Treatment- is a record singed by the resident/representative and the physician that indicates the resident's medical treatment wishes so that emergency personnel know what treatments the resident wants during medical emergency) and/or code status was known to the facility staffs and available to the staffs for review in an event of a code. 3. Ensure the Emergency Cart (EC, a storage cart that contains equipment necessary to perform life-saving procedures on residents experiencing a medical emergency) is maintained containing contents, devices/equipment that are accessible and used during CPR such as Ambu-bag (a type of device known as a bag valve mask, which is commonly used to provide respiratory support to patients who are not breathing or not breathing adequately),Glucometer (device used to check blood sugar levels), pulse oximeter (device used to check oxygen saturation levels in the blood), 20 gauge (inner size) Intravenous Catheter (IV catheter is a thin plastic tube that is inserted into the vein for the purpose of giving medications, blood, etc.), kerlix (a type of gauze), nebulizer kit (device used to provide treatment to the lungs), First Aid kit (a kit used for emergency). As a result of these deficient practices, the initiation of CPR was not initiated immediately, for Resident 41 with a full code status (resident wishes to be revived when breathing and/or heart stopped). Resident 41 was transferred to the General Acute Care Hospital (GACH) 1 Emergency Department (ED) on [DATE], after being found unresponsive, without pulse and not breathing. The GACH 1 ED Report indicated 911 (an emergency call system) and paramedics were called by the facility at approximately 5:52 AM. Resident 1 expired at the GACH 1 on [DATE] at 6:50 AM with the diagnosis of cardiac arrest. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:47 AM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, 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 of a resident) regarding the failure to ensure CPR was immediately performed on Resident 41. The survey team notified the Director of Nursing (DON), the Administrator (ADM) and the Regional Consultant (RC) of the IJ situation. On [DATE] at 6:03 PM, the IJ was removed in the presence of the ADM, and the DON after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified/confirmed onsite the facility's implementation of the IJ Removal Plan and the IJ situation was no longer present. The IJ Removal Plan dated [DATE] at 6:03 PM, included the following: 1. On [DATE], (DON) had a 1:1 (one on one) in-service with the licensed nurse assigned to Resident 41 regarding Medical Emergency Response. Disciplinary action was taken with licensed nurse who delayed the CPR on the full code resident and was suspended pending investigation. 2. On [DATE], the Medical Records Director (MRD) or designee completed a chart audit on every resident and compared the Advance Directive/Physician Orders for Life Sustaining Treatment (POLST) to the physician order for accuracy. 3. On [DATE] the facility emergency cart checklist was revised by the DON. The glucometer, glucose strips, lancets, nebulizer, and nebulizer kit were added on [DATE]. The updated form will be utilized by licensed nurses starting [DATE]. The emergency cart was checked by the DON on [DATE] for appropriate supplies and equipment. No issues were identified. 4. On [DATE], the Resource Nurse Consultant (RNC) and Respiratory Therapy Consultant designee educated licensed nurses and certified nurse assistance (CNAs) on the facility's policy and procedure for Medical Emergency Response and location of code status for each resident. Licensed nurses and CNAs were not permitted to work a shift until education was completed. Nurses on leave will receive education prior to their next scheduled shift. 5. On [DATE], the RNC and Respiratory Therapy Consultant initiated Code Blue (a code called out by the facility to alert other staffs about residents that needed emergency care) drill to be completed on all shifts randomly by using the facility landline's paging system located at the nurse's station, hallway outside room [ROOM NUMBER], between rooms [ROOM NUMBERS], activity room, rehabilitation room and office rooms (Administrator, DON, Dietary, SSD office), and announcing Code Blue to room. Licensed nurses and CNAs were in-serviced by the RNC regarding the paging system on [DATE]. The licensed nursing and CNAs staffs who were not scheduled to work on [DATE] will participate in the Code Blue drill during their scheduled shift. 6. On [DATE] the RNC, (Director of Nursing) DON and (Director of Staff Development) DSD conducted an audit of licensed nurses and certified nurse assistants (CNAs) CPR certification. No issues were identified. (continued on next page)

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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

7. Starting [DATE], newly hired licensed nurses and CNAs will have their CPR certification card on file and have competency prior to their scheduled shift.

8. Starting [DATE], DON or designee will audit new admissions chart to compare the resident's Advance Directives/ POLST to the physician orders for accuracy. This audit will continue for three months. Findings will be reviewed at the monthly QA (Quality Assurance) Committee meeting for discussion and recommendations.

9. Starting [DATE], ,d+[DATE] licensed nurse will print the daily code status from PCC orders and will place it in the binder labeled Code Status located at the nurse's station. The SSD will oversee that the code status is available and updated daily. In the absence of SSD, the license nurse working will verify that the code status is updated.

10. Starting [DATE], the POLST will be reviewed and verified by the DON and SSD immediately after admission of the resident to the facility. The RN Sup will oversee the POLST in the A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented on [DATE]. DON or designee to complete weekly mock (fake) code drills on all shifts and monitor code status compliance by interviewing licensed nurses about facility CPR policy and procedure, as well as requesting return demonstration of CPR process. Any trends will be discussed during monthly Quality Assurance meeting which will be held scheduled monthly. The DON will conduct compliance audits weekly for three months. Findings will be reported at monthly QA Committee meeting for discussion and recommendations.

11. Starting [DATE], the DON will randomly audit the emergency cart on a weekly basis in addition to the daily checks from ,d+[DATE] licensed nurse to ensure that the equipment and supplies are stocked as indicated on the emergency cart checklist. This audit will continue for three months. Findings will be reviewed at the monthly QAA (Quality Assurance) Committee meeting for discussion and recommendations.

Cross reference to F695 and F726

Findings:

1. A review of Resident 41's Admission Record indicated the facility originally admitted the resident on [DATE], and was readmitted on [DATE], with diagnoses that included congestive heart failure (failure of the heart to meet the body's demand), acute respiratory failure with hypoxia (a condition where a person do not have enough oxygen in the tissues of the body), chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs).

A review of Resident 41's Clinical Admission record, dated [DATE] timed at 3:18 PM, indicated Resident 41 was receiving oxygen at 3 liters per minute. The Clinical Admission indicated Resident 41's pulse oximetry (pulse oximetry is a painless, noninvasive method of measuring the saturation of oxygen in a person's blood) reading during admission to the facility was at 95% (a resting oxygen saturation level between 95% and 100% is regarded as normal for a healthy person) using oxygen administered via nasal cannula (a long plastic hose used to deliver oxygen into the nares). The Clinical Admission indicated Resident 41's discharge goal was to return home.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 41's History and Physical (H&P) dated [DATE], indicated the resident had the capacity to understand and make decisions. The H&P indicated one of Resident 1's diagnosis included Pneumonia (severe lung infection) treated. A review of Resident 41's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) with assessment reference date of [DATE], indicated the resident had moderate cognitive (thought process) impairment. The MDS indicated Resident 41 required partial/moderate assistance (helper does less than half the effort) in walking up to 10 feet and was not attempted to be assessed if she could walk 50 feet or more. The MDS indicated Resident 41 required supervision (helper provides verbal cues) on task such as oral hygiene, upper body dressing, sit to stand and bed mobility. The MDS indicated Resident 41 required partial/moderate assistance with toileting, shower and lower body dressing. A review of Resident 41's POLST signed by Resident 41 on [DATE], and signed and dated by Physician 1 on [DATE], indicated to attempt CPR to Resident 41 to restore breathing and heart circulation and beat. During the review of Resident 41's Progress Notes dated [DATE] timed at 5:30 AM, authored by Licensed Vocational Nurse (LVN) 1 indicated Resident 41 approached LVN 1 at the Nursing Station asking for another oxygen tank (a container with oxygen inside it, used for helping people to breathe). The Progress Notes indicated LVN 1 advised Resident 41 that Resident 41 still had half a tank left and will change (the oxygen tank) when it is lower. The Progress Notes indicated Resident 41 understood and just waited outside Nursing Station until staff finished with rounds. During the same review of Resident 41's Progress Notes dated [DATE] timed at 5:30 AM, the Notes indicated Noted Resident 41's oxygen tank outside Nursing Station. The Progress Notes indicated LVN 1 went inside Resident 41's room to ask if the resident still wanted her oxygen tank. The Progress Notes indicated Resident 41 was found unresponsive in bed with eyes slightly open, no pulse, no rise of chest (an indication that the resident was not breathing). [Resident 41] was still warm, blood sugar 301, unable to get blood pressure. The Progress Notes indicated 911 [paramedics] was called while staff (unknown) did CPR The Progress Notes indicated Resident 41 was transferred to the GACH on [DATE] at 6:25 AM, and family and Physician 1 was notified. A review of Resident 41's Change of Condition (COC) note dated [DATE] timed at 6:23 AM, indicated Found [Resident 41] unresponsive lying in bed with eyes slightly open. Called code blue and started CPR. 911 was called and noted patient (Resident 41) was full code, did CPR for 10 minutes before paramedics arrived and took over patient care. No pulse, after 25 minutes of CPR patient was transferred to GACH. The COC indicated Physician 1 was notified on [DATE] at 6:42 AM and the vital signs (measurement of the heart rate, breathing and blood pressure) were documented as follows: a. Blood pressure-,d+[DATE] (normal ranges between ,d+[DATE] to ,d+[DATE]) b. Respirations indicated 0-(number of breaths per minute normal range is between 12 to 20) c. Pulse-indicated-0 (heart rate per minute, normal range is 60 to 100) d. Apical pulse indicated 0 (number of times the heart beats per minute, normal range is 60 to 100) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. Temperature-97.5 F (Fahrenheit, a unit of measuring temperature [normal range 97 F to 99 F]) f. Oxygen Saturation 65% (low) (oxygen level in the blood-normal range ,d+[DATE]%) g. Blood sugar- 301 mg/dL (high) (milligrams per deciliter- normal range ,d+[DATE] mg/dL) A review of Resident 41's Emergency Department Report from GACH 1, dated [DATE], indicated the paramedics (an emergency personnel who performs CPR and other emergency care) was called by the facility staff on [DATE] at approximately 5:52 AM. The report indicated Resident 41 died on [DATE] at 6:50 AM. A review of Resident 41's GACH 1 Emergency Department (ED) Reports dated [DATE] timed at 7:14 PM, indicated Resident 41 was brought in by ambulance from the facility and found pulseless and not responsive. The GACH 1 ED report indicated the paramedics were called by the facility at approximately 5:52 AM and Resident 41 was last seen in her usual state of health 10 minutes prior. The GACH ED 1 report indicated paramedics were unable to obtain any return of spontaneous circulation in the field and were directed by base station to be transported. The report indicated Resident 41 arrived to GACH 1 ED with CPR in progress and Advanced Cardiac Life Support (ACLS, a set of clinical guidelines for the urgent and emergent treatment of life-threatening cardiovascular conditions that will cause or have caused cardiac arrest, using advanced medical procedures, medications, and techniques) in excess of 50 minutes, an additional dose of epinephrine (primary drug used in cardiac arrest, to increase cardiac output), sodium bicarbonate (medication used to treat metabolic acidosis [when acids build up in your body]), and calcium gluconate (medication used to manage cardiac arrest) were administered. The GACH 1 ED report indicated chest compressions continued with assisted ventilation (the movement of gas into and out of the lung by an external source connected directly to the patient) through endotracheal tube (a tube placed between the vocal cords through the airway to provide oxygen and inhaled gases to the lungs). The report indicated Resident 41 remained pulseless without cardiac activity on ultrasound and died on [DATE] at 6:50 AM. During an interview on [DATE] at 5:33 PM, the DON stated, there was no physician's order that indicated the code status for Resident 41. During a telephone interview on [DATE] at 6:04 PM, with the primary physician (Physician 1), Physician 1 stated he was notified by LVN 1 on [DATE] after Resident 41 was transferred to GACH 1. Physician 1 stated he could not recall the exact details of LVN 1's telephone notification on [DATE]. (continued on next page)

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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	During a telephone interview with LVN 1 on [DATE] at 6:28 PM, LVN 1 stated on [DATE], at around 5:30 AM, while LVN 1 was putting away medications, (Resident 41) approached him and asked if LVN 1 could change her portable oxygen tank because Resident 41 believed her oxygen tank was empty. LVN 1 stated he observed Resident 41's oxygen tank gauge (a medical device designed to display the pressure level in an oxygen tank) and saw that the oxygen tank gauge was still half full. LVN 1 stated he checked Resident 41's oxygen saturation and vital signs but could not recall and did not document the oxygen saturation level and vital signs results on [DATE]. LVN 1 stated that he did not do any other assessments (respiratory) because he needed to finish his medication pass and go home. LVN 1 stated he left Resident 41 sitting in a chair by the Nursing Station and proceeded to finish putting away medication in Medication Cart 1. LVN 1 stated after leaving Resident 41 in the Nursing Station, he continued to administer medications to the residents in seven rooms before going to another Nursing Station by Medication Cart 2 to retrieve Resident 41's medications which were kept in Medication Cart 2. LVN 1 stated as he was approaching Medication Cart 2, he observed Resident 41 was not at the Nursing Station anymore but Resident 41's oxygen tank was left sitting by the Nursing Station. LVN 1 stated he proceeded to go to Medication Cart 2 to remove Resident 41's medications before he decided to go to Resident 41's room. During the same telephone interview, on 5 /,d+[DATE] at 6:28 PM, LVN 1 stated as he entered Resident 41's room, LVN 1 observed Resident 41 lying in bed and not breathing. LVN 1 stated he went outside Resident 41's room to call for help and returned to Resident 41's bedside. LVN 1 stated when CNA 1 went to Resident 41's room, LVN 1 instructed CNA 1 to wait in the room, until he was able to review Resident 41's code status in the electronic medical records. LVN 1 stated he went outside Resident 41's room and went back to the Nursing Station and Medication Cart 2. LVN 1 stated he logged into the electronic medical records, but the electronic records did not indicate Resident 41's code status. LVN 1 stated he had to go to Nursing Station 1 to get Resident 41's paper chart to look for the POLST. LVN 1 stated Resident 41's POLST indicated Resident 41 was a full code (full support which includes cardiopulmonary resuscitation (CPR) if the patient has no heartbeat and is not breathing). LVN 1 stated after reviewing Resident 41's paper chart, LVN 1 returned to Resident 41's room to initiate CPR. LVN 1 stated that after completing about two full sets (consisting of 2 rescue breaths and 15 chest compressions) of CPR, LVN 1 instructed CNA 1 and CNA 2 to take over CPR, as he went outside Resident 41's room to the Nursing Station to call 911. LVN 1 stated he was the only licensed nurse during the shift (11 Pm to 7 AM) for the entire facility on [DATE]. During an interview on [DATE] at 7:31 PM with CNA 1, CNA 1 stated on [DATE] she was working inside another resident's room when she heard LVN 1 calling for help. CNA 1 stated LVN 1 initiated the CPR to Resident 41 after checking the code status of Resident 1. During a telephone interview on [DATE] at 7:58 PM with CNA 3, CNA 3 stated she did not hear LVN 1 called for Code Blue while she was in the restroom. CNA 3 stated when she got out of the restroom, she went to Resident 41's room and saw CNA 1, CNA 2, and CNA 7 performing CPR while LVN 1 was on the phone in the Nursing Station, calling 911. CNA 3 stated she touched Resident 41's hand and felt that Resident 41 was still warm. During a second telephone interview on [DATE] at 2:01 PM with Physician 1, Physician 1 stated facility staff should immediately initiate CPR when a resident is found to be unresponsive and without a pulse. Physician 1 stated a resident's code status should be entered into the resident's records upon admission. Physician 1 stated Resident 41 was under his care and was very frail. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During another interview on [DATE] at 1:56 PM with LVN 1, LVN 1 stated on [DATE] he saw CNA 1 in the hallway when he came out of Resident 41's room after finding Resident 41 unresponsive and not breathing. LVN 1 stated he instructed CNA 1 don't start anything because he stated he needed to find out Resident 41's code status first. LVN 1 stated he went to the medication cart and logged into the electronic records but was not able to find Resident 1's code status in the electronic records. Then LVN 1 stated he went to the Nursing Station and looked through Resident 41's paper chart to look for the resident's code status. LVN 1 stated he found Resident 1's POLST that indicated Resident 1 was a Full Code (attempt to provide CPR). LVN 1 stated when he learned of Resident 1's code status, he went back to the resident's room and initiated CPR. LVN 1 stated everyone was on standby and did not perform CPR until he found out the resident's code status. During a second interview on [DATE] at 4:07 PM with CNA 1, CNA 1 stated CNA 2 and CNA 7 were in the room when she arrived in Resident 1's room. CNA 1 stated CNA 3 arrived in the room sometime after. CNA 1 stated when she went into the room, she helped CNA 2 and CNA 7 place the backboard (a flat piece of platform that is placed under a person's body for the purpose of providing effective CPR) under Resident 1's body. CNA 1 stated LVN 1 started CPR after they put the backboard (a board designed to provide rigid support during movement of a person during CPR and to provide support to residents with suspected spinal or limb injuries). During a telephone interview on [DATE] at 2:06 PM with Resident 41's Family Member (FM 1), FM 1 stated the resident was in good spirits on [DATE]. FM 1 stated Resident 1 was planning on going home on [DATE]. FM 1 stated she talked to Resident 41 on [DATE], then on [DATE] at around 7 AM, she was informed by GACH 1 physician that Resident 41 passed away. During a concurrent interview and record review of the facility's policy and procedure (P&P) titled, Medical Emergency Response, revised on [DATE], on [DATE] at 6:11 PM, the DON stated the staff who first witnessed a medical emergency, such as finding an unresponsive and pulseless resident, should initiate immediate action, including CPR and calling for assistance. The DON stated the P&P indicated the CPR will only be stopped if a Do Not Resuscitate (DNR, instruction to not perform CPR on a resident) order is found to be in place in the resident's record. The DON stated staff should initiate CPR then have someone else verify the resident's code status. The DON stated delaying the CPR could result in a resident's death. During the same interview and record review on [DATE] at 6:11 PM with the DON, the facility's P&P titled, Cardiopulmonary Resuscitation (CPR), revised [DATE], the DON stated the P&P indicated facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and in the absence of advance directives or a Do Not Resuscitate order. DON stated staff should initiate CPR right away even without knowing the resident's code status. DON stated staff should perform CPR right away and should not delay CPR by searching for the code status. DON stated CPR can always be stopped if staff eventually find the code status as DNR. During a telephone interview on [DATE] at 6:15 PM with CNA 2, CNA 2 stated she saw Resident 41 near the Nursing Station on [DATE] at around 5:30 AM. CNA 2 stated she went to another resident's room and sometime later, she heard LVN 1 call for code blue. CNA 2 stated as she was going into Resident 1's room, LVN 1 was coming of the room to check for the code status. CNA 2 stated that CNA 2, CNA 1 and CNA 4 did not start CPR as instructed by LVN 1. CNA 2 stated that when LVN 1 came back to the room, that was when LVN 1 started CPR. CNA 2 stated she does not remember how long it took LVN 1 to find Resident 41's code status in the resident's records. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. During a concurrent observation of the completeness of the emergency cart and interview with the DON on [DATE] at 10:57 AM, the DON stated the following were missing from the facility's emergency cart: a. Ambu-bag (a type of device known as a bag valve mask, which is commonly used to provide respiratory support to patients who are not breathing or not breathing adequately) b. Glucometer (device used to check blood sugar levels) c. Pulse Oximeter (device used to check oxygen saturation levels in the blood) d. 20 Gauge Intravenous Catheter (IV, a thin plastic tube that is inserted to a person's vein for the purpose of giving medications, blood, etc.) e. Kerlix (a type of gauze) f. Nebulizer kit (device used to provide treatment to the lungs) g. First Aid Kit that had missing items. On [DATE] at 10:57 AM, the facility's document titled, Emergency Cart Checklist, revised ,d+[DATE], was reviewed with the DON. The DON stated the Emergency Cart Checklist was the current checklist used by the facility staff to check the completeness of the Emergency Cart. The DON stated the form was completed by the LVN (LVN 4) from the 11 PM to 7 AM shift on [DATE]. The DON stated she did not know why the checklist was checked off if some items are missing. During a concurrent interview and record review of Emergency Cart Checklist on [DATE] at 5:03 PM with LVN 4, dated ,d+[DATE], LVN 4 stated he completed the checklist on the night of [DATE]. LVN 4 stated he knew that there were missing supplies in the EC. LVN 4 stated he used to write an X if a supply was missing but was instructed by a former staff member of the facility to put a check instead. LVN 4 stated he was also instructed to report the missing items using a group chat in his cellphone. LVN 4 stated the group chat members included the facility Administrator, DON, Director of Staffing Development (DSD), and nurses from the 11:00 PM to 7:00 AM shift. During an interview on [DATE] at 5:45 PM with the DSD, the DSD stated licensed nurses were tasked and were trained to complete the Emergency Cart Checklist. The DSD stated the nurses were instructed to write an 'X' if an item is missing or write a line or check when the item is in the EC. The DSD stated staff are expected to notify the DSD via phone call or text message if an item or items are missing. The DSD stated nurses are also able to refill the EC and do not have to wait for the DSD's reply. The DSD further stated none of the nurses have informed him of any of the missing items in the EC. During an interview on [DATE] at 6:11 PM with the DON, the DON stated the EC is used in the case of an emergency such as a code blue. The DON stated the EC should be always restocked after use and ready for use. The DON stated not having the proper equipment in the EC could result in the delay of care, such as CPR, to residents that are experiencing a medical emergency. The DON stated Ambu-bags are used during a CPR procedure and should always be stocked in the EC. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Emergency Cart Checklist, unidentifiable, revision date, indicated the following must be present in the EC: a. First Drawer: Oxygen Sign and Gloves b. Second Drawer: Glucometer, Glucose Strips (a small piece of plastic that is used with a glucometer), thermometer (device used to check body temperature, pulse oximeter, lancets (a device used to prick a person's finger with an enclosed needle for the purpose of withdrawing a small amount of blood), alcohol pads, blood pressure cuff (device used to check blood pressure), and stethoscope (device used to listen to a person's heart, lungs, etc.) c. Third Drawer: Insulin syringe (a small cylindrical tube that is connected to a needle and a plunger), IV Catheter, Normal Saline (a liquid solution), Tapes, torniquet (an elastic band that is usually tied to a person's limb to facilitate insertion of an IV catheter), scissors, gauze, and kerlix. d. Fourth Drawer: [Nasal Cannula], non-rebreather mask (a mask that is connectable to an oxygen-delivery source to provide supplemental oxygen to a patient), oxygen tubing, Nebulizer, and Nebulizer kit. e. Fifth Drawer: Isolation gown (disposable gown that is worn to protect a person's clothing), face mask (a small piece of paper-like material that is worn to cover a person's nose and mouth), zip locks, trash bag, infectious waste bag, Ambu-bag, first aid kit, flashlight, and extension cord. A review of the facility's P&P titled, Medical Emergency Response, revised [DATE], indicated the employee who first witness or is first on site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance. The P&P also indicated a nurse will stay with the resident and designate a staff member to announce a Code Blue, if necessary, notify the physician and call 911 as needed. The P&P indicated Night shift supervisor or nurse will ensure that all emergency carts and equipment are inventoried and ready to use. The P&P also indicated staff will ensure emergency medications and equipment are inventoried and restocked. A review of Basic Life Support Provider Manual by American Heart Association, dated 2020, indicated: High-quality CPR (proper hand position and depth of chest compression) with minimal interruptions and early defibrillation (administering a controlled electric shock to allow restoration of the normal rhythm) are the actions most closely related to good resuscitation outcomes. High quality CPR if started immediately after cardiac arrest combined with early defibrillation can double or triple the chances of survival. These time-sensitive interventions can be provided both by members of the public and by healthcare providers. By standers who are not trained in CPR should at least provide chest compressions. Even without training, bystanders can perform chest compressions with guidance from emergency telecommunicators over the phone.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview, and record review, the facility failed to ensure one of five residents (Resident 22) had the correct setting for a low air loss mattress (a mattress filled with air that used for the prevention of pressure ulcers) for the prevention of pressure ulcers (wound caused when an area of skin is placed under pressure). This failure placed Resident 22 at risk of developing pressure ulcers. Findings: A review of Resident 22's Admission Record indicated Resident 22 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, chronic lung disease), diabetes mellitus (a chronic disease that result in high blood sugar levels in the blood), dysphagia (difficulty swallowing). A review of Resident 22's History and Physical (H&P), dated 2/6/24, indicated Resident 22 did not have the capacity to understand and make decisions. A review of Resident 22's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 2/13/2024, indicated Resident 22 has severe cognitive impairment. The MDS also indicated the resident requires moderate assistance (helper does half of the effort) in mobility such as sitting to lying and lying to sitting. The MDS also indicated Resident 22 required supervision (helper sets up) i bed mobility with rolling left and right. The MDS also indicated Resident 22 was at risk for developing pressure injuries. A review of Resident 22's assessment titled, Braden Scale for Predicting Pressure Ulcer Risk, dated 2/12/24, timed at 8:31 AM, indicated Resident 2 is at risk for developing pressure ulcers. A review of Resident 22's Medication Review Report, dated 4/30/2024, included an order that indicated: Wound Treatment: Low air loss mattress for skin management to be calibrated by resident ' s weight. Every shift monitor low air loss mattress for accurate settings every shift mark +(accurate)/-(not accurate). During a concurrent observation and interview on 5/3/2024 at 7:35 PM with Licensed Vocational Nurse (LVN) 5, Resident 22 was observed lying in bed and on a low air loss mattress. Resident 22's low air loss mattress was set at 9. LVN 5 stated Resident 22's low air loss mattress setting looks incorrect because a setting of 9 was for a resident that weighs more than 350 pounds (lbs. or pounds-a unit of measure). During a concurrent interview and record review on 5/3/2024 at 8:01 PM with LVN 5, LVN 5 stated Resident 22's low air loss mattress setting should be set according to Resident 22 ' s weight. LVN 5 stated Resident 22's current weight was 197.4 lbs., as of 5/1/2024 LVN 5 stated the setting should be at 5 instead of 9. LVN 5 stated the low air loss mattress was ordered for Resident 22's skin management and to prevent pressure ulcers. LVN 5 stated Resident 22's low air loss mattress was incorrectly set at 9 and would be ineffective in the prevention pressure ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 22's Weights and Vital Summary, dated 5/6/2024, indicated Resident 22 had a weight of 197.4 lbs., measured on 5/1/2024. During an interview on 5/5/2024 at 6:11 PM with the Director of Nursing (DON), the DON stated low air loss mattresses should be set to the correct setting as indicated by resident's current weight. The DON stated if the low air loss mattress was incorrectly set, pressure ulcer management was not done, and the resident would be at risk in developing pressure ulcers or other complications. A review of Resident 22's Care Plan titled, Potential for Impaired Skin Integrity, initiated on 3/2/2022 and revised on 12/9/2022, indicated proper usage of pressure reducing devices as an intervention. A review of the low air loss mattress ' manual titled, microAIR MA65 Series, indicated the comfort pressure level [depends] on the patient weight. A review of the facility's policy and procedure (P&P) titled, Use of Support Surfaces, revised 9/12/23, indicated support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure [ulcers]. The P&P also indicated support surfaces will be utilized in accordance with physician orders.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on interview and record review, the facility failed to assess, identify interventions, and services for Resident 41, who had diagnoses of respiratory failure with hypoxia (condition in which tissues of the body are starved of oxygen), pneumonia (lung inflammation) and chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and who was receiving continuous oxygen therapy by failing to: 1. Monitor and conduct respiratory assessment for complications associated with the use of oxygen and notify the primary physician (Physician 1). On [DATE] at 5:30 AM, Resident 41 verbalized not feeling well and asked the Licensed Vocational Nurse (LVN) 1 for her oxygen tank to be replaced because the resident, felt it was empty. 2. Evaluate and assess the need to obtain a physician's order for the use of oxygen therapy from the date of admission to the facility on [DATE], for Resident 41 who had a diagnosis of COPD and respiratory failure with hypoxia. 3. Notify and obtain a physician's order to administer Resident 41's oxygen at 3 liters per minute, via nasal cannula (NC-a medical device that consists of a small, flexible tube with two prongs that sit inside a patient's nostrils) and titrate (continuously measure and adjust the balance) to keep oxygen saturation (measures the percentage of oxygen in the blood) equal to or above 92% on [DATE] (3 days after admission to the facility). LVN 2 stated he did not obtain and clarify Resident 41's oxygen therapy orders from Physician 1 on [DATE]. 4. Develop and implement a resident- centered care plan (a formal process that correctly identifies existing needs and recognizes resident's potential needs or risks) to address and identify interventions based upon the resident's assessment and orders, for resident's history of respiratory distress (a serious lung condition that causes low blood oxygen) with hypoxia and need for oxygen therapy, as indicated in the facility's policy and procedures on Oxygen Administration and Comprehensive Care Plans. 5. Notify the physician of any changes in the resident's respiratory condition, including changes in vital signs (blood pressure, temperature, pulse, heart rate), oxygen concentrations, or evidence of complications associated with the use of oxygen, in accordance with the facility's policy and procedures on Oxygen Administration. 6. Ensure LVN 1 initiated immediate action, and performed cardiopulmonary resuscitation (CPR- involves chest compressions and mouth to mouth [rescue breaths with the aim to circulate blood and oxygen in the body), after finding Resident 41, unresponsive and not breathing, on [DATE], as indicated in the facility's policy and procedure titled Medical Emergency Response and Resident 41's Portable Orders for Life Sustaining Treatment (POLST - a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency). (continued on next page)

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F 0695

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

These failures resulted in the delay in assessment, care, and physician notification of Resident 41's respiratory condition when the resident verbalized her concern to LVN 1 that the resident felt her oxygen tank being empty and not feeling well, on [DATE] around 5:30 AM.

As a result, Resident 41 was transferred to the General Acute Care Hospital (GACH) 1 Emergency Department (ED) on [DATE]. The GACH 1 ED report indicated Resident 41 was brought in by ambulance from the facility and found pulseless and not responsive. The GACH 1 ED report indicated 911 paramedics were called by the facility at approximately 5:52 AM. Resident 41 passed away at GACH 1 on [DATE] at 6:50 AM with a diagnosis of cardiac arrest.

On [DATE] at 11:44 AM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, 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 of a resident) regarding the facility's failure to conduct respiratory assessment, identify interventions, and services for Resident 41, who had diagnoses of respiratory failure with hypoxia, pneumonia and COPD, and who was receiving continuous oxygen therapy. The survey team notified the Director of Nursing (DON), the Administrator (ADM) and the Regional Consultant (RC) of the IJ situation due to the facility's failure to ensure Resident 41 received respiratory assessment, treatments, and services when Resident 41 verbalized to LVN 1 the resident was not feeling well and asked for her oxygen tank to be replaced because the resident felt it was empty.

On [DATE] at 6:13 PM, while onsite at the facility, the survey team removed the IJ, in the presence of the ADM, and the DON after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified/confirmed onsite the facility's implementation of the IJ Removal Plan and the IJ situation was no longer present.

The IJ Removal Plan dated [DATE] at 6:03 PM, included the following:

1. Administrator notified the facility Medical Director of Immediate Jeopardy incident on [DATE].

2. On [DATE], licensed nurses identified was in-serviced by the DON regarding Physician notification when there is a change of condition focusing on respiratory system, respiratory assessment, and management of disease such as COPD, respiratory failure with hypoxia and oxygen therapy. Identified license nurse was suspended on [DATE] pending investigation.

3. On [DATE], the DON and Registered Nurse (RN) Supervisor reviewed the 13 residents with oxygen therapy orders, COPD diagnosis and respiratory distress with hypoxia for signs of respiratory distress or change of condition.

4. On [DATE], the Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) nurse reviewed in-house residents with diagnosis of COPD and respiratory failure with hypoxia for the implementation of resident centered care plans.

5. Starting [DATE], licensed nurses will check that residents are receiving the appropriate oxygen therapy as ordered at the start of their shift. When placing residents from oxygen concentrators to oxygen tanks, licensed nurses will verify the oxygen order to ensure that the liters per minute being administered matches the order.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross reference F678 Findings: During review of GACH 1 Pulmonology (a branch of medicine that specializes in diagnosing and treating diseases of the lungs and other parts of the respiratory system) Progress Notes dated [DATE] timed at 12:14 PM, indicated Resident 41 was previously admitted to GACH 1 on [DATE], with diagnoses including acute on chronic systolic heart failure (one or two main types of heart failure), severe aortic stenosis, end stage renal disease (final, permanent stage of kidney disease) on dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), dyspnea (shortness of breath), and hypoxia. The GACH 1 Pulmonology Progress Notes indicated Resident 41 felt weak and tired and was receiving 4 Liters (L, unit of measure) of Oxygen via Nasal Cannula (a small, flexible tube that contains two open prongs intended to sit just inside the nostrils to deliver supplemental oxygen). The progress note indicated Resident 41's chest x-ray results indicated small bilateral pleural effusions (buildup of excess fluid between the layers of the pleura [part of the respiratory tract that cushions the lung and reduces any friction that may develop between the lung, rib cage, chest cavity] outside the lungs). A review of GACH 1 Cardiology Progress Notes dated [DATE] timed at 8:21 AM, indicated Resident 41 was on 4 liters per minute of oxygen therapy during that time ([DATE]) and Resident 41 stated that breathing was stable at this level of oxygen. A review of Resident 41's Admission Record indicated the facility originally admitted the resident on [DATE], and was readmitted back to the facility on [DATE], with diagnoses that included acute on chronic systolic heart failure, acute respiratory failure with hypoxia, and COPD. A review of Resident 41's Clinical admitted d [DATE] timed at 3:18 PM, indicated Resident 41 was on Oxygen at 3 liters per minute. The Clinical Admission indicated Resident 41's pulse oximetry (pulse oximetry is a painless, noninvasive method of measuring the saturation of oxygen in a person's blood) reading during admission to the facility was at 95% (a resting oxygen saturation level between 95% and 100% is regarded as normal for a healthy person) using oxygen administered via nasal cannula. The Clinical Admission indicated Resident 41's discharge goal was to return home. A review of Resident 41's History and Physical (H&P) dated [DATE], indicated the resident had the capacity to understand and make decisions. The H&P indicated one of Resident 41's diagnosis included pneumonia. A review of Resident 41's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) with assessment reference date of [DATE], indicated the resident had moderate cognitive (thought process) impairment. The MDS indicated Resident 41 required partial/moderate assistance (helper does less than half the effort) in walking up to 10 feet. The MDS indicated Resident 41 required supervision (helper provides verbal cues) on task such as oral hygiene, upper body dressing, sit to stand and bed mobility. The MDS indicated Resident 41 required partial/moderate assistance with toileting, shower and lower body dressing. A review of Resident 41's POLST signed and dated by Physician 1 on [DATE], indicated to attempt and perform CPR, if the resident was found with no pulse and is not breathing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER College Vista Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4681 Eagle Rock Blvd. Los Angeles, CA 90041	

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 41's physician's order dated [DATE], authored by LVN 2, indicated to administer oxygen via NC at 3 liters (unit of measurement) per minute, may titrate oxygen to maintain oxygen saturation greater or equal to 92% every shift for shortness of breath. A review of Resident 41's care plan dated [DATE], indicated the resident was at risk for rehospitalization due to COPD . and hypertension (high blood pressure). The care plan interventions included to notify the physician if resident presents with signs and symptoms of respiratory distress . such as adventitious lung sounds (any sounds that occur in addition to normal breathing sounds), shortness of breath . A review of Resident 41's care plan dated [DATE], indicated the resident has pneumonia. The care plan interventions included to auscultate (listening to the sounds of the body during a physical examination) lung sounds, listen for crackles and diminished breath sounds due to atelectasis (the collapse of part or all of a lung, is caused by a blockage of the air passages). During the review of Resident 41's Progress Notes dated [DATE] timed at 5:30 AM, authored by Licensed Vocational Nurse (LVN) 1 indicated Resident 41 approached LVN 1 at the Nursing Station asking for another oxygen tank (a container with oxygen inside it, used for helping people to breathe). The Progress Notes indicated LVN 1 advised Resident 41 that Resident 41 still had half a tank left and will change (the oxygen tank) when it is lower. The Progress Notes indicated Resident 41 understood and just waited outside Nursing Station until staff finished with rounds. During the same review of Resident 41's Progress Notes dated [DATE] timed at 5:30 AM, the Notes indicated Noted Resident 41's oxygen tank outside Nursing Station. The Progress Notes indicated LVN 1 went inside Resident 41's room to ask if the resident still wanted her oxygen tank. The Progress Notes indicated Resident 41 was found unresponsive in bed with eyes slightly open, no pulse, no rise of chest, [Resident 41] was still warm, blood sugar 301, unable to get blood pressure. The Progress Notes indicated 911 [paramedics] was called while staff (unknown) did CPR The Progress Notes indicated Resident 41 was transferred to the GACH on [DATE] at 6:25 AM, and family and Physician 1 was notified. A review of Resident 41's Change of Condition (COC) note dated [DATE] timed at 6:23 AM, indicated Found [Resident 41] unresponsive lying in bed with eyes slightly open. Called code blue (a declaration of or a state of medical emergency and call for medical personnel and equipment to attempt to resuscitate a patient) and started CPR. 911 was called and noted patient was full code, did CPR for 10 minutes before paramedics arrived and took over patient care. No pulse, and after 25 minutes of CPR and resident was transferred to GACH. The COC indicated Resident 41's oxygen saturation was 65% and blood sugar of 301. The COC indicated Physician 1 was notified on [DATE] at 6:42 AM. A review of Resident 41's Medication Administration from [DATE] to [DATE] indicated an order to administer ipatropium-albuterol (made up of two different bronchodilators (a drug that relaxes and opens the airways, used to treat COPD) inhalation solution 0.5 - 2.5 milligrams (mg) / 3 milliliters (ml). Inhale 3 ml orally, every 6 hours as needed for shortness of breath. The MAR indicated X marks from [DATE] to [DATE], indicating no inhalation solution was signed out and provided to Resident 41. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 41's GACH 1 Emergency Department (ED) Reports dated [DATE] timed at 7:14 PM, indicated Resident 41 was brought in by ambulance from the facility and found pulseless and not responsive. The GACH 1 ED report indicated the paramedics were called by the facility at approximately 5:52 AM and Resident 41 was last seen by facility staff (LVN 1) in her usual state of health 10 minutes prior. The GACH 1 ED report indicated paramedics were unable to obtain any return of spontaneous circulation in the field and were directed by base station to be transported. The report indicated Resident 41 arrived to GACH 1 ED with CPR in progress and Advanced Cardiac Life Support (ACLS, a set of clinical guidelines for the urgent and emergent treatment of life-threatening cardiovascular conditions that will cause or have caused cardiac arrest, using advanced medical procedures, medications, and techniques) in excess of 50 minutes, an additional dose of epinephrine (primary drug used in cardiac arrest, to increase cardiac output), sodium bicarbonate (medication used to treat metabolic acidosis [when acids build up in your body]), and calcium gluconate (medication used to manage cardiac arrest) were administered. The GACH 1 ED report indicated chest compressions continued with assisted ventilation (the movement of gas into and out of the lung by an external source connected directly to the patient) through endotracheal tube (a tube placed between the vocal cords through the airway to provide oxygen and inhaled gases to the lungs). The report indicated Resident 41 remained pulseless without cardiac activity on ultrasound (an imaging test that uses sound waves to make pictures of organs) and died on [DATE] at 6:50 AM. During an interview and concurrent record review of Resident 41's Clinical Admission notes and Physician Orders with the DON on [DATE] at 5:33 PM, the DON stated Resident 41 was admitted to the facility on [DATE] with oxygen being administered via NC. The DON stated Resident 41's Oxygen therapy order was initiated on [DATE]. The DON stated after reviewing all of Resident 41's care plans developed from [DATE] to [DATE], the resident's care plans did not indicate care plans were developed for Resident 41's use of oxygen, history of hypoxia, and shortness of breath. During the same concurrent interview and record review of Resident 41's COC notes, Progress Notes, vital signs records, and assessment notes from [DATE] to [DATE] with the DON, on [DATE] at 5:33 PM, the DON stated there was no documented evidence found indicating a respiratory assessment and treatment was performed on [DATE], by LVN 1, when Resident 41 verbalized to LVN 1 that Resident 41 was not feeling well and felt her oxygen tank was empty. During a telephone interview on [DATE] at 6:04 PM, with Physician 1, Physician 1 stated Resident 41 was on continuous oxygen therapy due to her medical condition of cancer, systolic heart failure and pneumonia. Physician 1 stated he would expect the licensed nurse assigned to care for Resident 41, to conduct a respiratory assessment of Resident 41 when she verbalized to LVN 1 on [DATE] that Resident 41 felt like her oxygen tank was empty, because Resident 41 might not be feeling well. Physician 1 stated that LVN 1 should have checked Resident 41's vital signs and respiratory assessment because of Resident 41's respiratory diagnoses (pneumonia, COPD, hypoxia) and notified Physician 1 immediately. Physician 1 stated he was notified by LVN 1 on [DATE] after Resident 41 was transferred to GACH 1. Physician 1 stated he could not recall the exact details of LVN 1's telephone notification on [DATE]. (continued on next page)

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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 0695

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During a telephone interview with LVN 1 on 5 /,d+[DATE] at 6:28 PM, LVN 1 stated on [DATE], at around 5:30 AM, while LVN 1 was putting away medications, Resident 41 came up to LVN 1 and asked if LVN 1 could change her portable oxygen tank because Resident 41 believed her oxygen tank was empty. LVN 1 stated he observed Resident 41's oxygen tank gauge (a medical device designed to display the pressure level in an oxygen tank) and saw that the oxygen tank gauge was still half full. LVN 1 stated he checked Resident 41's oxygen saturation and vital signs but could not recall and did not document the oxygen saturation level and vital signs results on [DATE]. LVN 1 stated that he did not do any other assessments (respiratory) or treatment to Resident 41, because he needed to finish his medication pass on [DATE] and go home. LVN 1 stated he left Resident 41 sitting in a chair by the Nursing Station and preceded to finish putting away medications in Medication Cart 1. LVN 1 stated after leaving Resident 41 in the Nursing Station, he continued to administer medications to other residents in seven rooms before going to another Nursing Station by Medication Cart 2, to retrieve Resident 41's medications which were kept in Medication Cart 2. LVN 1 stated as he was approaching Medication Cart 2, he observed Resident 41 was not at the Nursing Station anymore but Resident 41's oxygen tank was left by the Nursing Station. LVN 1 stated he proceeded to go to Medication Cart 2 to remove Resident 41's routine medications before he decided to go to Resident 41's room.

During the same telephone interview, on 5 /,d+[DATE] at 6:28 PM, LVN 1 stated as he entered Resident 41's room on [DATE], LVN 1 observed Resident 41 lying in bed and not breathing. LVN 1 stated he went outside Resident 41's room to call for help and return to Resident 41's bedside. LVN 1 stated when Certified Nurse Assistant (CNA) 1 came to Resident 41's room, LVN 1 instructed CNA 1 to wait in the room, until he was able to review Resident 41's code status in the electronic medical records. LVN 1 stated he went outside Resident 41's room back to the Nursing Station and Medication Cart 2. LVN 1 stated he logged into the electronic medical records, but the electronic records did not indicate Resident 41's code status. LVN 1 stated he had to go to Nursing Station 1 to get Resident 41's paper chart to look for the POLST. LVN 1 stated Resident 41's POLST indicated Resident 41 was a full code (full support which includes cardiopulmonary resuscitation (CPR), if the patient has no heartbeat and is not breathing). LVN 1 stated after reviewing Resident 41's paper chart, LVN 1 returned to Resident 41's room to initiate CPR. LVN 1 stated that after completing about two full sets (consisting of 2 rescue breaths and 15 chest compressions) of CPR, LVN 1 instructed CNA 1 and CNA 2 to take over CPR, as he went outside Resident 41's room to the Nursing Station to call 911. LVN 1 stated he was the only licensed nurse during the shift (11 PM to 7 AM) for the entire facility on [DATE].

During an interview on [DATE] at 7:31 PM, with CNA 1, CNA 1 stated that in the morning of [DATE], between 5:30 AM to 6 AM, CNA 1 stated she was sitting by the Nursing Station and recalled observing Resident 41 walking up to the Nursing Station and verbalized not feeling well to LVN 1. CNA 1 stated seeing LVN 1 leaving the Nursing Station after talking to Resident 41 and LVN 1 continued passing medications on his assigned residents. CNA 1 stated that on [DATE], she heard LVN 1 shouting for help. CNA 1 stated she went to Resident 41's room, where she found LVN 1 standing right by the resident. CNA 1 stated LVN 1 instructed her to wait and remain at Resident 41's bedside, while LVN 1 went out to check Resident 41's code status.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the same interview on [DATE] at 7:31 PM, with CNA 1, CNA 1 stated LVN 1 returned to Resident 41's bedside and initiated chest compressions while CNA 2 used the Ambu bag (a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing) to give Resident 41 two rescue breaths. CNA 1 stated LVN 1 instructed to check for Resident 41's vital signs. CNA 1 stated she remembered the pulse oximeter (an electronic device that measures the saturation of oxygen in the blood) not reading and the blood pressure machine showing an error result. CNA 1 stated LVN 1 instructed CNA 1 to take over the chest compressions while LVN 1 went back to the Nursing Station to call 911. CNA 1 stated she recalled LVN 1 returning to Resident 41's room and continued to perform CPR to Resident 41, until the paramedics arrived and took over the CPR. During a telephone interview on [DATE] at 7:49 PM with LVN 2, LVN 2 stated that on [DATE], she noted in Resident 41's previous ([DATE] to [DATE]) GACH 1 records that the resident should be on oxygen therapy. LVN 2 stated that on [DATE], LVN 2 entered the physician order for oxygen at 3 liters per minute via NC in Resident 41's electronic records but did not inform or verify the oxygen orders with Physican 1. LVN 1 stated she assumed that the admitting licensed nurse just forgot to put in the oxygen orders for Resident 41 upon admission to the facility on [DATE]. During another interview on [DATE] at 1:56 PM with LVN 1, LVN 1 stated he saw CNA 1 on [DATE] upon finding Resident 41 unresponsive and not breathing. LVN 1 stated he instructed CNA 1 and stated, don't start anything because LVN 1 needed to find out Resident 41's code status first. LVN 1 stated he went to the medication cart and logged into the electronic records but was not able to find Resident 41's code status. LVN 1 stated he went to the Nursing Station and looked through Resident 41's paper chart to look for the resident's code status. LVN 1 stated he found Resident 41's POLST that indicated Resident 41 was a Full Code (attempt to provide CPR). LVN 1 stated when he learned of Resident 41's code status, he went back to the resident's room and initiated CPR. LVN 1 stated that on [DATE], everyone was standing by for CPR because we did not know the code status yet. During a concurrent interview and record review of the facility's policy and procedure (P&P) titled, Medical Emergency Response, revised on [DATE], on [DATE] at 6:11 PM, the DON stated the staff who first witnessed a medical emergency, such as finding an unresponsive and pulseless resident, should initiate immediate action, including CPR and calling for assistance. The DON stated the P&P indicated the CPR will only be stopped if a Do Not Resuscitate (DNR, instruction to not perform CPR on a resident) order is found to be in place in the resident's record. The DON stated staff should initiate CPR then have someone else verify the resident's code status. The DON stated delaying the CPR could result in a resident's death. During a telephone interview on [DATE] at 2:06 PM with Resident 41's Family Member (FM 1), FM 1 stated the resident was in good spirits on [DATE]. FM 1 stated Resident 41 was planning on going home on [DATE]. FM 1 stated she talked to Resident 41 on [DATE], then on [DATE] at around 7 AM, she was informed by GACH 1 physician that Resident 41 passed away. During a telephone interview on [DATE] at 6:15 PM with CNA 2, CNA 2 stated she saw Resident 41 near the nursing station on [DATE] at around 5:30 AM. CNA 2 stated she went to another resident's room and sometime later, she heard LVN 1 call for code blue. CNA 2 stated as she was going into Resident 41's room, LVN 1 was coming of the room to check for the code status. CNA 2 stated that CNA 2, CNA 1 and CNA 4 did not start CPR as instructed by LVN 1. CNA 2 stated that when LVN 1 came back to the room, that was when LVN 1 started CPR. CNA 2 stated she does not remember how long it took LVN 1 to find Resident 41's code status in the resident's records. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's policy and procedure titled Notification of Changes, with a revision date of [DATE], indicated the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident representative when there is a change of condition requiring notification. A review of the policy and procedure titled Oxygen Administration dated [DATE] indicated oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The policy indicated the resident's care plan shall identify interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: the type of oxygen delivery system, when to administer, such as continuous or intermittent and /or when to discontinue, equipment setting for the prescribed flow rates, monitoring of oxygen saturation levels and/or vital signs as ordered, and monitoring for complications associated with the use of oxygen. The policy indicated staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen. A review of the facility's policy and procedure titled Comprehensive Care Plans, dated [DATE], indicated the facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. A review of the facility's policy and procedure titled, Medical Emergency Response, revised on [DATE], indicated The employee who first witnesses or is first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid . The policy indicated, a nurse will assess the situation and determine the severity of the emergency, stay with the resident, designate a staff member to announce a Code Blue, if necessary, and call 911 as needed. The policy further indicated, CPR will continue unless there is a DNR (do not resuscitate) order in place .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on interview and record review, the facility failed to ensure five out of five employees had the specific competency and skill sets necessary to provide cardiopulmonary resuscitation (CPR-a lifesaving emergency procedure for a victim who has signs of cardiac arrest [a situation when a victim becomes unresponsive, no normal breathing, and no pulse] consisting of a combination of chest compressions, mouth-to-mouth, or mechanical breathing [a device used to help someone breathe]) for Resident 41. This deficient practice resulted in the delay in the initiation of CPR and life saving measures for Resident 41 and placed residents at risk for not receiving appropriate services, treatments and unsafe level and type of identified care necessary for the resident population. Cross Reference to F678 and F695 Findings: A review of Resident 41 ' s Admission Record indicated the facility originally admitted the resident on [DATE], and was readmitted on [DATE], with diagnoses that included acute on chronic systolic (congestive) heart failure (failure of the heart to meet the body ' s demand), acute respiratory failure with hypoxia (a condition where a person do not have enough oxygen in the tissues of the body), chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs). A review of Resident 41's History and Physical (H&P) dated [DATE], indicated the resident had the capacity to understand and make decisions. The H&P indicated one of Resident 1 ' s diagnosis included Pneumonia (severe lung infection)- treated. A review of Resident 41's POLST (a Portable Orders for Life Sustaining Treatment- is a record singed by the resident/representative and the physician that indicates the resident ' s medical treatment wishes so that emergency personnel know what treatments the resident wants during medical emergency) signed by Resident 41 on [DATE], and signed and dated by Physician 1 on [DATE], indicated to attempt CPR to Resident 41 to restore breathing and heart circulation and beat. A review of Resident 41's Change of Condition (COC) note dated [DATE] timed at 6:23 AM, indicated Found [Resident 41] unresponsive lying in bed with eyes slightly open. Called code blue and started CPR. 911 was called and noted patient (Resident 41) was full code, did CPR for 10 minutes before paramedics arrived and took over patient care. No pulse, after 25 minutes of CPR patient was transferred to GACH. The COC indicated Physician 1 was notified on [DATE] at 6:42 AM and the vital signs (measurement of the heart rate, breathing and blood pressure) were documented as follow: Blood pressure-,d+[DATE] (normal ranges between ,d+[DATE] to ,d+[DATE]) Respirations indicated 0-(number of breaths per minute normal range is between 12 to 20) (continued on next page)

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Pulse-indicated-0 (heart rate per minute, normal range is 60 to 100)- 0

Apical pulse indicated 0 (number of times the heart beats per minute, normal range is 60 to 100)

Temperature-97.5 F (Fahrenheit, a unit of measuring temperature [normal range is 97 F to 99 F]),

Oxygen Saturation 65% (low) (oxygen level in the blood-normal range ,d+[DATE]%)

Blood sugar- 301 mg/dL (high) (milligrams per deciliter- normal range ,d+[DATE] mg/dL)

A review of Licensed Vocational Nurse (LVN) 1 ' s employee file indicated LVN 1 received CPR certification by National CPR Foundation on [DATE].

A review of Certified Nursing Assistant (CNA) 1 ' s employee file indicated CNA 1 received Basic Life Support by American Heart Association on [DATE].

A review of CNA 2 ' s employee file indicated CNA 2 received Basic Life Support by American Heart Association on [DATE].

A review of CNA 3 ' s employee file indicated CNA 3 received Basic Life Support by American Heart Association on [DATE].

A review of CNA 4 ' s employee file indicated CNA 4 received Basic Life Support by American Heart Association on [DATE].

During an interview on 5 /,d+[DATE] at 6:28 PM, LVN 1 stated as he entered Resident 41 ' s room and found the Resident 41 lying in bed and not breathing. LVN 1 stated he went outside Resident 41 ' s room to call for help and returned to Resident 41 ' s bedside. LVN 1 stated when CNA 1 went to Resident 41's room, LVN 1 instructed CNA 1 to wait in the room, until he was able to review Resident 41' s code status in the electronic medical records. LVN 1 stated he went outside Resident 41's room and went back to the Nursing Station and Medication Cart 2. LVN 1 stated he logged into the electronic medical records, but the electronic records did not indicate Resident 41's code status. LVN 1 stated he had to go to Nursing Station 1 to get Resident 41's paper chart to look for the POLST. LVN 1 stated Resident 41 ' s POLST indicated Resident 41 was a full code (full support which includes cardiopulmonary resuscitation (CPR), if the patient has no heartbeat and is not breathing). LVN 1 stated after reviewing Resident 41' s paper chart, LVN 1 returned to Resident 41 ' s room to initiate CPR. LVN 1 stated that after completing about two full sets (consisting of 2 rescue breaths and 15 chest compressions) of CPR, LVN 1 instructed CNA 1 and CNA 2 to take over CPR, as he went outside Resident 41' s room to the Nursing Station to call 911.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:07 PM with CNA 1, CNA 1 stated CNA 2 and CNA 4 were in the room when she arrived in Resident 1 ' s room. CNA 1 stated CNA 3 arrived in the room sometime after. CNA 1 stated when she went into the room, she helped CNA 2 and CNA 4 place the backboard (a flat piece of platform that is placed under a person ' s body for the purpose of providing effective CPR) under Resident 1's body. CNA 1 stated LVN 1 started CPR after they put the backboard (a board designed to provide rigid support during movement of a person during CPR and to provide support to residents with suspected spinal or limb injuries). During the same interview on [DATE] at 6:11 PM with DON, the facility ' s policy and procedure (P&P) titled, Medical Emergency Response, revised [DATE], was concurrently reviewed with DON. The DON stated the staff who first witnessed a medical emergency, such as finding an unresponsive and pulseless resident, should initiate immediate action, including CPR and calling for assistance. DON stated the P&P indicated the CPR will only be stopped if a Do Not Resuscitate (DNR, instruction to not perform CPR on a resident) order is found to be in place in the resident's record. DON stated staff should initiate CPR then have someone else verify the resident's code status. DON stated delaying CPR could result in a resident's death. During the same interview on [DATE] at 6:11 PM with DON, the facility ' s P&P titled, Cardiopulmonary Resuscitation (CPR), revised [DATE], was concurrently reviewed with DON. DON stated the P&P indicated facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and in the absence of advance directives or a Do Not Resuscitate order. DON stated staff should initiate CPR right away even without knowing the resident ' s code status. DON stated staff should perform CPR right away and should not delay CPR by searching for the code status. DON stated CPR can always be stopped if staff eventually find the code status as DNR. During a telephone interview on [DATE] at 6:15 PM with CNA 2, CNA 2 stated she saw Resident 41 near the Nursing Station on [DATE] at around 5:30 AM. CNA 2 stated she went to another resident ' s room and some time later, she heard LVN 1 call for code blue. CNA 2 stated as she was going into Resident 1 ' s room, LVN 1 was coming of the room to check for the code status. CNA 2 stated that CNA 2, CNA 1 and CNA 4 did not start CPR as instructed by LVN 1. CNA 2 stated that when LVN 1 came back to the room, that was when LVN 1 started CPR. CNA 2 stated she does not remember how long it took LVN 1 to find Resident 41 ' s code status in the resident's records. A review of the facility's policy and procedure tiled Nursing Services and Sufficient Staff: dated [DATE] indicated the facility would provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The policy indicated providing care included, but not limited to, assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs. A review of Basic Life Support Provider Manual by American Heart Association, dated 2020, indicated: High-quality CPR with minimal interruptions and early defibrillation (administering a controlled electric shock to allow restoration of the normal rhythm.) are the actions most closely related to good resuscitation outcomes. High quality CPR if started immediately after cardiac arrest combined with early defibrillation can double or triple the chances of survival. These time-sensitive interventions can be provided both by members of the public and by healthcare providers. By standers who are not trained in CPR should at least provide chest compressions. Even without training, bystanders can perform chest compressions with guidance from emergency telecommunicators over the phone. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Medical Emergency Response, revised [DATE], indicated the employee who first witness or is first on site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance. The P&P also indicated a nurse will stay with the resident and designate a staff member to announce a Code Blue if necessary, notify the physician and call 911 as needed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on interview and record review, the facility failed ensure the attending physician acted upon and document in the residents' clinical records the rationale to the consultant pharmacist recommendation during the drug regimen to re evaluate use of psychotropic medication Seroquel (medications that affects mood and behavior) to consider whether or not the medication be reduced or discontinued for one of five sampled residents (Resident 37) and consider GDR (Gradual Dose Reduction- decreasing the dosage of medication slowly) with eventual discontinuation if appropriate and document rationale for necessity to continue therapy. This deficient practice increased had the potential for the resident to receive medications unnecessarily and develop an adverse reaction or side effects (undesired effect) to the medication that could result in a decline in the resident ' s well being and result in a negative impact on the resident ' s overall physical, mental, and psychosocial well-being. Findings: A review of Resident 37 ' s Admission Record indicated Resident 37 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain cause by chemical imbalances in the blood), cellulitis (a bacterial skin infection) of left lower limb. A review of Resident 37 ' s History and Physical dated 2/29/2024 indicated Resident 37 has the capacity to understand and make decisions. A review of Resident 37 ' s Medication Review Report, dated 5/1/2024 to 5/31/2024, indicated an active order for Seroquel oral tablet 25 mg (Quetiapine Fumarate) by mouth twice a day for psychosis manifested by agitation and or restlessness A review of Consultant Pharmacist ' s Medication Regimen Review, dated 3/21/2024, indicated the consultant pharmacist recommended to the attending physician to reevaluate use and need of psychotropic medication and consider whether or not it can be reduced or discontinued, and consideration of GDR with eventual discontinuation if appropriate, or document rationale for necessity to continue therapy. Further review of the consultant pharmacist ' s recommendation indicated that under the Physician/prescriber response section was observed blank. During and interview and concurrent record review on 5/06/2024 at 6:15PM of Resident 37's clinical record indicated with Director of Nursing , DON stated there was no documented response from Resident 37 ' s primary physician regarding the pharmacist's recommendation or documented evidence the facility had notified Resident 37's primary physician of the pharmacist ' s recommendations for Resident 37's continued use of Seroquel 25milligrams. During the same interview on 5/06/2024 at 6:16PM with DON, DON stated the facility is supposed to contact the physician first, obtain the physician's response to the pharmacy recommendations and document on Resident 37 ' s medical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled Medication Regimen Review, with a revision date of 12/19/2022, indicated the facility shall act upon all recommendations according to procedures for addressing medication regimen review irregularities

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, facility failed to ensure the route of medication administration matched the label on the bubble pack (a type or medication tablets packaging), the physician ' s orders and Medication Administration Record (MAR) for Bromocriptine Mesylate (medication used to treat Parkinson ' s Disease [a disorder of the nervous system that affects movement, including tremors) and Divalproex Sodium (medication used to treat seizures and bipolar disorder [disorder associated with episodes of mood swings ranging from depressive lows to manic highs) for one of one sampled resident (Resident 17). This deficient practice had the potential to result in Resident 17 to receive medications in error or through the wrong route that could lead to choking. Findings: A review of Resident 17 ' s Admission Record indicated an admission on 1/3/2024 with diagnoses of metabolic encephalopathy (an alteration in consciousness caused due to brain dysfunction), parkinsonism (a motor syndrome that manifests as rigidity, tremors, and bradykinesia [slowness of movement and speed]) and unspecified dementia. A review of Resident 17 ' s History and Physical assessment dated [DATE], indicated Resident 17 did not have the capacity to understand and make decisions. A review of Resident 17 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/19/2024, indicated, Resident 17 had severely impaired cognition (thought process). A review of Resident 17's Order Summary, physician order for the following: Dated 4/30/2024, indicated Bromocriptine Mesylate Oral (by mouth) tablet 2.5 milligram (mg, unit of measure) and give 4 tablets via gastrostomy tube (G-Tube, a tube placed directly into the stomach through an abdominal wall incision for the administration of food, fluids, and medications) three times a day related to Parkinsonism. Dated 4/30/2024, indicated Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 mg, give 2 capsules via PEG-Tube (G-tube) three times a day for mood disorder manifested by angry outbursts. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview and record review of Resident 17 ' s Medication Administration Record (MAR) with Licensed Vocational Nurse (LVN) 2 on 5/4/2024 at 8:49 AM, LVN 2 was observed verifying Resident 17 ' s medications and MAR. LVN 2 verified Resident 17 ' s bubble pack (a type or medication tablets packaging) label for Bromocriptine Mesylate which did not match the physician ' s order on the MAR. The bubble pack label for Bromocriptine Mesylate indicated to be given via oral route, and two out of five doses of Bromocriptine Mesylate were already removed from the bubble pack. LVN 2 stated Resident 17 ' s bubble pack label for Divalproex Sodium did not match the physician ' s order on the MAR and two out of fourteen doses of Divalproex Sodium were already removed. LVN 2 stated she would clarify the order with the pharmacy. During an interview with LVN 2 on 5/4/2024 at 9:33 AM, LVN 2 stated she would call the pharmacy to clarify the medication order because it should match the physician ' s order. LVN 2 stated it was important to make sure the physician order and the label on the bubble package matched and correct because Resident 17 could choke if she was given the medications orally. LVN 2 stated it would be a medication error, which was why staff should check for the right medication, right route, right dosage, and right order. LVN 2 stated she would call pharmacy to clarify and then change the order sticker on the bubble packs so that it matches the physician ' s order. During an interview with Registered Nurse (RN) 1 on 5/4/2024 at 9:44 AM, RN 1 stated the pharmacy was called and clarified the medication orders. RN stated it was okay to change the label to indicate the right route for the medications. RN 1 stated it was important to clarify orders and make sure the bubble pack label about medication route of administration matches the physician ' s orders so that the nurses won ' t have any mistakes when administering the medications. A review of the facility ' s policy and procedure titled Medication Administration, dated 12/19/2022 indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The policy indicated to review the medication administration record (MAR) to identify medication to be administered and to compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route and time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview, and record review, the facility failed to follow their enhanced standard precaution (a resident-centered and activity-based approach for preventing multi-drug resistant organism [MDRO Bacteria that resist treatment with more than one antibiotic] transmission in skilled nursing facilities (SNF) for one of five sampled residents (Resident 20) when staff was observed providing care to Resident 20 without wearing the proper personal protective equipment (PPE equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses). This failure placed Resident 20 at risk for exposure to infectious organisms increasing the risk of infections and a spread of infection to other residents and the facility. Findings: A review Resident 20's Admission Record indicated the resident was originally admitted to the facility on [DATE] , and readmitted on [DATE], with diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), diabetes mellitus (a chronic disease that result in high blood sugar levels in the blood), and gastro-esophageal reflux disease. A review of Resident 20's History and Physical (H&P), dated 3/18/24, indicated Resident 20 did not have the capacity to understand or make decisions. The H&P also indicated Resident 20 had a gastrostomy tube (G-tube, a plastic tube that is inserted through the abdomen and into a person ' s stomach, sometimes referred to as feeding tube). A review of Resident 20's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 3/22/24, indicated Resident 20 had severe cognitive (thought process) impairment. A review of Resident 20's Medication Review Report, dated 4/30/24, indicated Resident 20 had an order for enhanced standard precautions due to long term use of [G-tube]. During an observation on 5/3/24 at 8:16 PM inside Resident 20's room, Licensed Vocational Nurse (LVN) 5 was observed providing care and handling Resident 20's G-tube without wearing a gown. During an interview on 5/3/24 at 8:22 PM with LVN 5, LVN 5 stated Resident 20 was on enhanced standard precaution (ESP) as indicated by the blue sticker next to the Resident 20's name plate before entering Resident 20's room. LVN 5 stated he had provided G-tube care to Resident 20 by flushing water into Resident 20's G-tube. LVN 5 stated not wearing a gown while providing g-tube care to Resident 20, and that a gown should have been worn to protect LVN 5's clothes and to prevent the potential spread of infections to other residents. During an interview on 5/5/24 at 6:11 PM with the Director of Nursing (DON), the DON stated ESP was ordered for specific residents that could expose staff to bodily fluids such as when providing G-tube care, due to splashing of fluids. The DON stated staff who do not use proper PPE, a gown, mask, and gloves, would put residents at risk for contracting infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised 4/22/24, indicated enhanced barrier precautions, or enhanced standard precautions (ESP), is designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities. The P&P indicated high resident care activities include device care of feeding tubes.