

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555727	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Laurel Creek Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 Estates Dr. Fairfield, CA 94533	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0678 Level of Harm - Actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and treatment in accordance with professional standards of practice and resident's needs for Resident 1 by failing to administer oxygen (a life sustaining gas that travels from lungs to the blood and helps convert food into energy), when Resident 1 was found with critically low oxygen levels in the blood (a dangerous, life-threatening condition when the oxygen not reaching body tissues often causing confusion, rapid breathing, and altered level of consciousness-a change in arousal and responsiveness that ranges from mild to severe e.g. lethargy to coma state). In addition, the facility did not initiate cardiopulmonary resuscitation (CPR -an emergency treatment performed in an effort to preserve the function of the brain and other vital organs when a person has no pulse (pulse can be checked from an artery located on wrist or neck) and is not breathing or not breathing adequately), when Resident 1 was found unresponsive, pulseless, and not breathing. These failures denied Resident 1 life-sustaining treatments and interventions during an emergency and resulted in Resident 1's death.A review of Resident 1's Face Sheet (a summary of patient's demographic, clinical information, physician name) indicated the facility admitted Resident 1 on 5/2/26. Resident 1's diagnoses included endometrial cancer (cancer of the inner lining of the womb), pulmonary embolism (a condition when a blood clot get stuck into the lungs obstructing blood flow), and depression.A review of Resident 1's Minimum Data Set (MDS- an assessment tool) dated 5/8/26 indicated that the resident scored 14 out of 15 in a Brief Interview for Mental Status (BIMS, an assessment tool used to determine cognition status using total scores with a range of zero to 15, a score of 13-15 denotes intact cognition) indicating the resident was cognitively intact. The MDS assessment indicated Resident 1 used wheelchair for mobility and required maximum (staff does the majority of the lifting and maneuvering) assistance from staff to transfer to and from wheelchair.A review of Resident 1's Physician Orders for Life -Sustaining Treatment (POLST form - a document containing medical orders to be honored by health care staff during a medical emergency) signed by Resident 1 and the physician on 8/19/22 indicated Resident 1's choices were for full treatment/full code (perform resuscitation and all appropriate lifesaving measures, including oxygen, CPR, and other interventions used to help a person breathe when the airway is blocked) if found pulseless or not breathing.A review of nursing progress note (NPN) documented by licensed nurse (LN 1) on 6/23/26 at 12:12 p.m., indicated Resident 1 left the facility at 8:30 a.m., via wheelchair accompanied by her husband to have laboratory blood work done at the clinic and returned back to facility on 6/23/26 at 11:15 a.m.A further review of NPN indicated that upon returning resident to her room, Resident 1's husband requested LN 1 to call 911 due to the resident's decline in responsiveness. LN 1 documented that on 6/23/26 at 11:25 a.m., Resident 1 was found unresponsive, with heart rate elevated to 120 beats per minute (BPM- unit of measurement; (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0678 Level of Harm - Actual harm Residents Affected - Few	Administrator (ADM). The ADM stated LN 1 was not allowed to administer oxygen but could have started the CPR. The ADM was asked what life-saving measures were initiated during the 10 minutes when Resident 1 was found unresponsive with critically low oxygen saturation until the resident became pulseless and not breathing. The ADM stated, This resident was a large woman and it would take 3-4 staff to get her to the floor and start CPR. The ADM stated the facility was well staffed, had an RN on duty on that day and the staff was [would have been] able to move Resident 1 to the floor and start CPR, but it was not done. The ADM validated that Resident stayed in her wheelchair where she died, and no life-saving measures were provided. The ADM added, From what is documented, I do not see that RN [LN 2] was involved to administer oxygen and any help with CPR. I don't see that RN was assisting LVN and CPR [was] not started. A review of the facility's P&P titled, Emergency Procedure - Cardiopulmonary Resuscitation and Basic life Support [BLS], dated 2001, indicated that personnel must complete the training on the initiation of cardio pulmonary resuscitation (CPR) and basic life support (BLS) for victims of sudden cardiac arrest [means the heart suddenly stops beating and pumping blood effectively to the rest of the body]. The P&P indicated, Staff are trained to follow current American Heart Association (AHA) guidelines and recommendations for the sequence of resuscitation. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a staff member who is trained in CPR/BLS shall initiate CPR. The facility select and identify, designate a team leader on each shift who is responsible for coordinating and directing other team members during rescue efforts. A review of the current American Heart Association (AHA) guidelines published 10/22/25, retrieved from cpr.heart.org on 7/8/26 indicated that resuscitation should be started immediately once cardiac arrest is recognized. The AHA indicated the following sequence for a healthcare provider: 1. Recognize cardiac arrest (the person is unresponsive), not breathing normally or is only gasping); check for a pulse for no more than 10 seconds and if no pulse begin CPR. 2. Activate the emergency response system; call for help, have someone bring the crash cart. 3. Begin high-quality CPR immediately, starting with chest compressions. The AHA emphasized that any delay in initiating resuscitation efforts should be minimized because every minute without CPR decreases the chance of person's survival.		