STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676105	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Lubbock	4910 Emory Lubbock, TX 79416

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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 Note: The nursing home is disputing this citation.	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** 43150 Based on interview and record review, the facility failed to provide basic life support, including cardiopulmonary resuscitation (CPR) for 1 of 7 residents reviewed for advanced directives. (Resident #1, #2, #3, #4, #5, #6, and #7). The RN A did not initiate CPR for Resident #1 when Resident #1 was found with no pulse or respirations. Resident #1 was listed as Full Code (all resuscitation procedures are provided to keep a person alive during a medical emergency). This failure could place all residents in the facility who requested a full code status at risk of death. An Immediate Jeopardy situation was identified on [DATE] at 3:20 PM. The Immediate Jeopardy was removed on [DATE] at 3:24 PM The facility remained out of compliance at a scope of isolated incident of and a severity level of potential actual harm due to the facility's need to complete in service training and evaluate the effectiveness of the corrective systems. This failure could place all residents in the facility who requested a full code status (everything is done to keep a person alive) at risk of death. Findings included: Resident #1: Record review of an Admission Record dated for Resident #1 showed a [AGE] year old male with an admitted [DATE] with diagnoses of Secondary malignant neoplasm (a cancer that forms in the cells of the breasts) of other parts of nervous system, Gastro esophageal reflux disease without esophagitis (acid reflux), Constipation, Hyperkalemia (high potassium), Benign prostatic hyperplasia (age associated prostate gland enlargement that can cause urinary difficulty) with lower urinary tract symptoms, Generalized anxiety disorder, Muscle weakness (generalized), Malignant neoplasm of unspecified site of unspecified male breast, History of falling. Admission record did not specify Resident #1's code status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of an Entry MDS (Minimum Data Set) assessment dated [DATE] for Resident #1 listed no BIMs (Brief interview for Mental Status). The most recent MDS dated [DATE] did not address advance directives or code status for Resident #1. Record review of Resident #1's care plan for Advance Directives, dated [DATE] revealed Social worker has discussed advanced directives and code status with resident and/or resident representative. The interventions were listed as: The facility staff will assure my advanced directives are discussed and appropriate paperwork is provided to me and placed in my medical record when returned to facility, Assure Advanced directives are discussed, and appropriate paperwork is obtained. No code status listed in orders. The care plan dated [DATE] for Resident #1 did not address code status. Record review of facility provided the code status for Resident #1, titled, Order Group Report (Advance Directive), dated from [DATE] to [DATE], stated: under order name: D/C Code STATUS FULL CODE may use AED, Dx: Secondary malignant neoplasm of other parts of nervous system. D/C date: [DATE] A Cardiopulmonary Resuscitation Advanced Directives Policy dated [DATE]. Indicated, .When a patient is found to be without heartbeat or respirations by any staff member the patient's medical record must be checked to ensure that the patient's wishes are followed. If there are no advanced directives or a Full Code status the licensed staff will start CPR . Record review of Resident #1's nurse notes, dated [DATE] at 5:34 AM, stated: revealed Resident declined to take any prn pain medication thru the night. Signed and dated by Medication Aide. Record review of Resident #1's nurse notes, dated [DATE] at 8:23 AM, stated revealed: went into patient's room at 0653 to find him pale, not breathing, no pulse was present, no lung or heart sounds were present. Called DON,911, wife and the physician shortly after finding. Signed and dated by RN A Record review of Resident #1's nurse notes, dated [DATE] at 8:50 AM, stated: Med aid went to patients' room and noticed patient was not responding, left room to call RN. RN went in room at 0653, assessed patient. RN checked for a pulse near carotid and brachial, listened for lung and heart sounds. RN found no pulse or sounds. Called DON at 0707 to inform of patient's current status, was ordered to call 911. called 911 at 0715, EMS arrived at 0724. called physician at 0716, no answer. RN left a message for the physician to inform him of patient's status. RN called wife at 0717 to inform of patient's current status. Wife said she can arrive in an hour and a half because she lives out of town. Signed and dated by RN A. Record review of Resident #1's nurse notes, dated [DATE] at 8:23 AM, stated: went into patient's room at 0653 to find him pale, not breathing, no pulse was present, no lung or heart sounds were present. Called DON,911, wife and the physician shortly after finding. Signed and dated by RN A Record review of Resident #1's nurse notes, dated [DATE] at 5:34 AM, stated: Resident declined to take any prn pain medication thru the night. Signed and dated by Medication Aide. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of facility provided code status for Resident #1, titled, Order Group Report (Advance Directive), dated from [DATE] to [DATE], stated: under order name: D/C Code STATUS FULL CODE may use AED, Dx: Secondary malignant neoplasm of other parts of nervous system. D/C date: [DATE] Record review of EMS report, titled, Pre hospital Care Report Summary, for Resident #1, dated [DATE], revealed: Record revealed that the call came in at 07:18:12, dispatched at 07:18:26, En Route at 07:18:28, On Scene at 07:21:37, Patient Contact at 07:23:00 Billing Disposition stated: Dead after arrival, patient dead at scene resuscitation attempted (without transport) deceased Patient: Dead After Arrival Assessments: Airway Breathing Rate; Apneic (is a temporary cessation of breathing, where the muscles used for inhalation stop moving). Skin Color: Cyanotic, pale Skin temperature: Cool Skin condition: Normal Comments: Resident is apneic and pulseless Type of CPR Provided: Compressions Manual Ventilation Passive Ventilation with Oxygen ([DATE] 07:51) Reason CPR/Resuscitation Discontinued: Protocol/Policy Requirements Completed. First Arrest Rhythm of the Patient; Asystole (flatline, is a cardiac arrest rhythm where the heart's electrical and mechanical activity stops completely). Who first initiated CPR: EMS Responder (transport EMS) Arrest Witnessed: unwitnessed. Narrative History Text: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	9742 responded to facility for cardiac arrest (sudden, unexpected loss of heart function, breathing, and consciousness). Upon arrival at bedside, two caregivers were noted and stated that they just cleaned and changed the patient. The patient was noted to be unresponsive, pulseless, and apneic (is a temporary cessation of breathing, where the muscles used for inhalation stop moving). The patient did not present with rigor (a postmortem change resulting in the stiffening of the body muscles due to chemical changes in the myofibrils). The patient was moved to the floor and CPR initiated CPR (cardiopulmonary resuscitation) initiated. OPA (oropharyngeal airway insertion) and NRB (non rebreather mask) were placed for passive airway and IO (intraosseous vascular) access obtained. Cardiac monitor with stat pads were placed. The initial rhythm of the patient was noted to be asystole. Staff then relayed to EMS (emergency medical services) that the patient was found unresponsive and pulseless at 0658, and that resuscitation (the action or process of reviving someone from unconsciousness or apparent death) was not attempted. The staff reported that the patient is full code. Cardiac arrest medications were administered, and the patient was successfully intubated with end tidal co2 monitoring used to confirm placement, lung sounds auscultated (examine a patient by listening to sounds from the heart, lungs, or other organs). The patient was noted to remain in asystole (flatline, is a cardiac arrest rhythm where the heart's electrical and mechanical activity stops completely) throughout. Signal 28 was called at 0751. Information was given to LPD (police department). EMS (emergency medical services) cleared the scene. During an interview with the Administrator on [DATE] at 11:28 AM,. The Administrator stated that the policy for code status stated was that CPR should be initiated to for a full code resident unless the seven signs of death are present. The Administrator stated that the RN A did not initiate CPR because all seven signs of death were present. The Administrator did not specify the seven signs of death. The Administrator stated that the documentation that the RN A made is incomplete and not finished. The Administrator did not give a reason the RN A had unfinished documentation. The Administrator stated that if the resident was not showing all seven signs of death, then she should have initiated CPR. The Administrator stated that education was provided to the RN immediately. The education that had been provided was through in services on [DATE] for Active Signs of Death, BON guidance positions for nurses (LVN & RN) position statement 15.2 & 15.20, CN are to print code statuses at beginning of every shift and keep on them at all times during shift. During an interview with EMS Staff on [DATE] at 2:37 PM, The EMS Staff member stated that when the team had gotten on scene, that there were two staff members that had already cleaned the resident. The EMS staff member had stated that Resident #1 appeared deceased , no pulse, no respirations, slightly cool to touch, jaw was loose, and did not have any darkening of the skin. The EMS Staff member stated that they had to get the RN to ask what the resident's code status was. The EMS staff member stated that the RN should have initiated CPR immediately when she had found the resident and continued CPR until EMS arrived. The EMS staff member stated that the RN stated that Resident #1 was a full code. The EMS Staff member stated that there was no reason the RN should not have initiated CPR. EMS staff member,, She stated that the body of Resident #1 was not in rigor mortis. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with RN A on [DATE] at 5:00 PM., RN A stated that she arrived on shift at 6 am and received report from LVN. RN stated that during report, Resident #1 was stable, and he had refused his pain medication. RN A stated that CMA E went to give Resident #1's medication before 7 am and that was when she realized he was unresponsive and not breathing. RN A stated that is when the CMA E came to get her, and RN A went to Resident #1's room to assess him. RN A stated that his skin was cold to touch and no movement. RN A stated that Resident #1 was cyanotic (blue) and had rigor mortis. RN A stated that she immediately contacted the DON and was instructed to call 911. RN A then contacted the Physician and he said, Thank you for letting me know. RN A stated that she contacted the wife after the physician. RN A stated that on the computer Resident #1 was DNR, so she did not initiate CPR. RN A stated that a few days ago when he was admitted his vitals were stable, he was cognitive, and no issues other than his cancer. RN A stated, This was unexpected. RN A stated, How long will you be investigating this. During an interview with CNA G on [DATE] at 5:36 PM. CNA G stated that she had worked the evening shift of [DATE] and had gotten off shift the morning of [DATE]. CNA G stated that she had been the only CNA G on shift for three hundred hall and she had one nurse on shift. CNA G stated that Resident #1 had expired later that afternoon because a co worker had called and told her. CNA G stated that she had done her rounds at 4:45 4:50 AM with Resident #1. CNA G stated that Resident #1 was sleeping and had visible respirations when she had gone in Resident #1'shis room to change his foley bag. CNA G stated that Resident #1 had moved a little (changed positions in bed) and she was trying to be quiet and not wake him. CNA G stated that she normally makes made her rounds at 12 am, 2 am, and 4 am. CNA G stated that she will normally walk around and do checks on the residents in between making her rounds. CNA G stated that she was supposed to leave at 6 am that morning and supposed to do report with the on coming CNA G but the oncoming CNA G was late, so she just left. CNA G stated that the resident was breathing and asleep at 4:45 AM and did not show and signs of distress through the night. During an interview with LVN C on [DATE] at 8:46 PM. LVN C stated that she worked the evening of [DATE] and had gotten off the morning of [DATE]. LVN C stated that she had given report to RN A the morning of [DATE]. LVN C stated that she had given report with the RN A at the desk and then they had gone and did the narcotics count. LVN C stated that the nurse would normally check residents when coming onto shift. LVN stated that she would usually check on her resident's every 2 3 hours throughout the night. LVN C stated that she had last seen Resident #1 around 5:30 AM on [DATE] and he was awake and talking to her. LVN C stated that Resident #1he had denied his pain medication and had had told her that he was not in any pain and did not want anything for pain. LVN C stated that she was not surprised because the night before Resident #1 had been in a lot of pain, and Resident #1he had new Fentanyl patches put on earlier that day and had not been in pain since then. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with the DON on [DATE] at 11:39 AM. The DON stated that she was notified by RN A at 707 AM on [DATE] of the unresponsive resident. The DON stated that the RN A had notified her that Resident #1 had no pupil response, no pulse, cold to the touch, and no signs of life. The DON stated that the RN A had not initiated CPR because she told DON that based on her assessment that she had done, he showed signs of death, and it would not have be appropriate to perform CPR. The DON stated that rigor mortis is the settling of blood and starts in face, pale, cyanotic (blue), will turn into blood settling and stiffness. The DON stated that RN A did not complete her notes. The DON did not specify why RN A did not finish her notes. The DON stated that on the nurse notes it stated that resident was cold to touch, pale, but did not state rigor mortis. The DON stated that while she was coming into the facility, the EMS was leaving the building, and they had stopped her and asked her why CPR was not initiated. The DON stated that she had not been here and could not determine what should have been done because she had not done the assessment. The DON stated that RN A stated to her that the resident was, Dead, Dead, The DON stated that per her education from TBON (Texas Board of Nursing), that RN's can make the decision if CPR is appropriate or not upon assessment. The DON stated that she can cannot question another nurse's judgement as a nurse. The DON stated that if a nurse were wrong, she would educate that nurse, but since the DON was not in the facility to do her own assessment, she could not judge the RN's assessment. The DON stated that she immediately started in services for active signs of death, BON guidance positions for nurse's (LVN & RN) position statement 15.2 & 15.20, CN are to print code statuses at beginning of every shift and keep on them at all times during shift. signs of impeding death and code status. During an interview with CMA E on [DATE] at 1: 37 PM. CMA E stated that she was the person that had found the Resident #1 unresponsive in his room the morning of ,d+[DATE]/.2025. CMA E stated that she was on shift the morning of [DATE], her shift had been from 6 am 2pm. CMA E stated that she had found Resident #1 unresponsive around 6:35 am 6:40 am. CMA E stated that she had gone to Resident #1's room and the door was slightly cracked open, and she had knocked and called out his name. CMA E stated that she did not hear any response from Resident #1, so she had knocked again and called out his name. CMA E stated that she still did not hear anything and then she had opened the door and walked in to check on him. CMA E stated that she had thought it was strange that Resident #1 did not answer because she did not notice any breathing or respirations. CMA E stated that she had shaken Resident #1'shis shoulder and had called his name. CMA E stated that Resident #1's eyes were closed, and he was laying back but to the side a little and his mouth was open, and the head of his bed was slightly elevated. CMA E stated that Resident #1 was not stiff because when she shook him, he was very loose when she had shaken him;, and he wasn't firm or stiff. CMA E stated that she had not seen any different coloration of his (Resident #1's) face or lips and no blotchiness. CMA E stated that she had immediately left Resident #1's room and went down the hall to get RN A. CMA stated that she and the RN had went back to Resident #1's room and RN A had taken took the pulse by wrist on Resident #1. CMA E stated that when RN A had taken Resident #1's pulse by his wrist, his wrist was loose. CMA E stated that the RN A stated that she did not feel a pulse. CMA E stated that her and RN A had then went to the nurse's station, and the RN A had gotten on the computer to look up a phone number and had then she contacted the DON. CMA E stated that the DON had then instructed RN A to call 911. CMA E stated that she had left the nurse's station after that because she had to administer the medications to other residents. CMA E stated that she did not witness RN A performing any CPR at all. CMA E stated that she would know what the code status of a resident is was because all the nurse's would pull a code status at the beginning of the shift, and they carry that in their pocket to check every resident. CMA E stated that Resident #1 was listed as a full code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with CNA H on [DATE] at 2:16 PM. CNA H stated that she was on shift the morning that Resident #1 was found unresponsive. CNA H stated that her shift was 6 am 2pm on [DATE]. CNA H stated that she clocked in at 6:37 AM. CNA H stated that when she came in, she went room to room to write down all resident's names down so that she would know who needed showers. CNA H stated that she went to talk to RN A about shower sheets. CNA H stated that while she was talking with RN A about shower sheets, the CMA E came in and stated that a resident is was unresponsive. CNA H stated that when she saw Resident #1, he was pale and foaming out of the mouth. CNA H stated that she did not see RN A initiate CPR. CNA H stated that they had found Resident #1 at 6:42 AM. CNA H stated that RN A thought that Resident #1 was a DNR because RN A stated that Resident #1 was a DNR to her. CNA H stated that Resident #1 was not stiff, and he did not have any discoloration of the skin. CNA H stated that she knew this that because she helped to clean up the body before EMS got to the facility. CNA H stated that Resident #1 was in bed and was turned to the side with his eyes closed. CNA H stated that they usually just ask the nurse of the code status of the residents. Record review of a report provided by the facility on [DATE] at 4:36 PM, between the dates of [DATE] to [DATE]., indicated there were 50 of 93 residents with a full code status. A Cardiopulmonary Resuscitation Advanced Directives Policy dated [DATE] .Indicated, .When a patient is found to be without heartbeat or respirations by any staff member the patient's medical record must be checked to ensure that the patient's wishes are followed. If there are no advanced directives or a Full Code status the licensed staff will start CPR . Record review of facility provided policy, titled, Cardiopulmonary Resuscitation (CPR): Basic Life Support (BLS)/ Hands Only CPR, date revised on February 12, 2020; stated: Policy: CPR (BLS and/or Hands Only) will be initiated for residents that experience a witnessed or unwitnessed cardiopulmonary arrest while in the community. CPR will not be initiated (or continued) for any resident that: a. Has a DNR order on record. b. Shows American Heart Association (AHA) signs of clinical death as defined in the AHA Guidelines. Procedure: Preparations: 1. Licensed clinical staff involved in resuscitative efforts will obtain and/or maintain certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR). 2. Unlicensed personnel will receive hands on training annually (at minimum) by DON or designee. 3. DON or designee will conduct a Mock Code (educational simulation of actual arrest) annually at minimum for training purposes. 4. Emergency equipment and supplies necessary for CPR/BLS will be maintained in the community. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	5. Information will be provided upon admission on CPR/BLS policies and advance directive to each resident/ representative. General Guidelines; 1. The goal of CPR is to try to maintain life until the emergency medical response team arrives to deliver Advanced Life Support (ALS). 2. If an individual is found unresponsive by an employee of the community the employee will initiate CPR unless: a). It is known that a Do Not Resuscitate order exists for the resident; or b). In the event of an unwitnessed cardiac event an RN may determine that CPR would be futile and an inappropriate intervention if all signs of death are present: i. The resident is unresponsive. ii. The resident has no respiration. iii. The resident has no pulse. iv. Resident's pupils are fixed and dilated. v. The resident's body temperature indicated hypothermia: skin is cold relative to the resident's baseline skin temperature. vi. The resident has generalized cyanosis, and vii. There is presence of livor mortis (venous pooling of blood in dependent body parts). 3. RN must document description of discovery for example: treatment undertaken; findings of assessment; individual notified, result of communication and presence or absence of witness. Equipment and Supplies: 1. Personal Protective equipment including: gloves, masks, gowns, and eyewear as appropriate. 2. Airway delivery device such as: pocket face mask, Ambu bag and/or mouth shields. Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or community BLS training material. Bystander/Unlicensed Staff: 1. Summon for help 2. Request AED 3. Check for Responsiveness (for example shaking, tap shoulder and shout are you okay etc.) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Hands only CPR is CPR without rescue breathing. AHA has recommended it for use by untrained layperson/bystander (non licensed) on teens or adults who collapse (observed and unobserved). This involves calling 911 or sending someone to call and pushing hard and fast in the center of the chest. Record review of website viewed for American Heart Association at, date retrieved on [DATE], stated: The American Heart Association (AHA) considers a person clinically dead if they have obvious signs of irreversible death, such as rigor mortis, decapitation, or decomposition. The AHA also considers a person clinically dead if they have a valid advance directive or DNAR order that states they do not want resuscitation. Signs of irreversible death rigor mortis, dependent lividity, decapitation, transection, and decomposition. Advance directives A valid, signed, and dated advance directive that states the person does not want resuscitation. A valid, signed, and dated DNAR order Signs of irreversible death Rigor mortis, which is when the body stiffens after death. Dependent lividity Decapitation Transection Decomposition Advance directives A valid Do Not Resuscitate (DNR) order. A valid, signed, and dated advance directive that states the person does not want resuscitation. A living will, which is a written direction to physicians about the patient's wishes for end of life care. The AHA recommends that rescuers initiate CPR unless they see obvious signs of irreversible death, have a valid DNR order, or could be injured. Record review of facility provided in services, dated [DATE], titled, Active Signs of Death, with forty seven staff signatures including RN A, stated: (continued on next page)

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	676105	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Lubbock	4910 Emory Lubbock, TX 79416

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Signs that someone is near death: 1. Shortness of breath 2. Isolation and drifting away 3. Decreased appetite and thirst 4. Nausea and vomiting 5. Anxiety 6. Constipation 7. Fatigue 8. Incontinence 9. Skin Conditions 10. Delirium 11. The death rattle 12. Pain Record review of facility provided in services, dated [DATE], titled, BON Guidance Positions for Nurses, with seventeen staff signatures including RN A, stated: The Registered Nurse Scope of Practice: The RN takes the responsibility and accepts accountability for practicing within the legal scope of practice and is prepared to work in all health care settings and may engage in independent nursing practice without supervision by another health care provider. The RN is responsible for providing safe, compassionate, and comprehensive nursing care to patients and their families with complex healthcare needs. Record review of facility provided in services, dated [DATE], titled, print code statuses at beginning of every shift and keep on them at all times during shift, with eighteen staff signatures including RN A, stated: How to print Code Statuses: 1. Go to reports in system 2. Select order group report 3. Enter room numbers for your hall 4. Select Active order under order status (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	5. Search by order group Advanced Directives The Administrator was notified on [DATE] at 3:20 PM., that an Immediate Jeopardy situation was identified due to the above failures. The IJ template was emailed to the Administrator on [DATE] at 3:43 PM. The facility's Plan of Removal was accepted on [DATE] at 8:12 A.M., and included: Summary of Details which lead to outcomes: On [DATE], during a complaint survey initiated at the facility a surveyor. provided an IJ Template notification that the Survey Agency has determined that the conditions. at the center constitute immediate jeopardy to resident health. F678 The notification of the alleged immediate jeopardy states as follows: F678 The resident was a 65 y/o male, admitted on [DATE] with a diagnosis of malignant neoplasm of the breast with secondary malignant neoplasm of other parts of the nervous system. The facility allegedly failed to provide basic life support, including CPR, prior to the arrival of emergency. medical personnel for 1 (Resident #1) of 1 resident. Resident #1's code status was listed as full code. How other residents with the potential to be affected by the same deficient practice. will be identified. Any resident with full code status have potential to be affected by the alleged. deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. DON (Director of Nursing) or designated nurse will in service all licensed nurses on policy and procedure for identifying code status on residents by 10:00 pm on [DATE]. No nurses will be allowed to work until training has been completed. Any nurses who did not receive training before 10:00 P.M. on [DATE] will receive training prior to the start of (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	their next shift. This education was initiated on [DATE]. DON or designee will educate all staff on emergency policy and procedures when residents. are found to be unresponsive by 10:00 pm on [DATE]. No nurses will be allowed to work. until training has been completed. Any nurses who did not receive training before 10:00 P.M. on [DATE] will receive training prior to the start of their next shift. This education was initiated on [DATE]. DON or designee will monitor 10 staff members per week for 4 weeks on competency of 7 signs of death/ active signs of death, competency of nurses printing code statuses from EMR and on person, and CNA competency on code status on POC. This monitoring was initiated. on [DATE]. How the corrective action(s) will be monitored to ensure the deficient practice is being corrected and will not recur (i.e., what program will be put into place to monitor the continued effectiveness of the system changes); and Proof of the education will be submitted to QA committee Involvement of Medical Director Medical Director was notified and met with interdisciplinary team on [DATE]. Involvement of QA An Ad Hoc QAPI meeting will be held with the Medical Director, facility administrator, director of nursing, and social services director to review plan of removal. Administrator will forward results of audits monthly to the QAPI Committee for review and/or action and be reviewed monthly x 90 days. Who is responsible for implementation of process? The Director of Nursing/designee will be responsible for implementation of New Process. The New Process/ system will be started on [DATE] and no employee be able to return to work until they (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	complete the Inservice. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on [DATE]. Interviews for POR: Interviews with 1 RN, 1 LVN, 4 CNAs and 2 CMAs regarding the training they had received on signs of impeding death, and code status of a resident on [DATE] by 2:30 PM, showed that the staff had an understanding of the education provided. During an interview with CMA E for training for POR on [DATE] at 11:34 AM. CMA E stated that she had received an in service training by the DON. CMA E stated that the training was about how to locate the code status of a resident. CMA E stated that the nurses are supposed to carry a printout paper of all resident's code status. CMA E stated that for CNA's can find the code status of a resident by getting into the POC and clicking on the resident's name and that will pull up the code status. CMA E stated that the CMA's are not required to print out the code status. CMA E stated that the other training that they received was for the signs of death which are pain, sleeping a lot, not able to eat or drink, not able to get out of bed. You would report these signs through chain of command. CMA E stated that she would then step out in the hall and keep her eyes on the resident and yell for help if she noticed t [TRUNCATED]