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	345268	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted from 09/24/24 through 09/26/24. The following intake was investigated NC00222145. One (1) of 1 allegation resulted in a deficiency. Intake NC00222145 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.10 at tag F580 at a scope and severity (IJ) CFR 483.12 at tag F600 at a scope and severity (IJ) CFR 483.24 at tag F678 at a scope and severity (IJ) CFR 483.25 at tag F684 at a scope and severity (IJ) The tags F600, F678, and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 09/19/24 and was removed on 09/20/24. A partial extended survey was conducted.	F 000	Past noncompliance: no plan of correction required.	
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		

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

Electronically Signed | 10/11/2024

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(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations

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F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Medical Director (MD) interviews, the facility failed to notify the physician for a resident who had a significant change in condition. On 09/18/24 Resident #1 was observed with audible congestion, difficulty swallowing, and was trying to cough up phlegm. The MD or Nurse Practitioner (NP) were not notified. On 09/19/24 Resident #1 had his mouth open with clear phlegm noted in his mouth and he was coughing. Resident #1's vital signs included a blood pressure (BP) of 90/86 (normal 120/80), pulse of 48 (normal range 60-100), oxygen at 89% (normal range between 95% and 100%) on room air, and respirations of 12 (normal range 12-18). He had audible congestion, and his skin was extremely hot to touch. The MD or Nurse Practitioner (NP) were not notified. At 5:00 AM Resident #1 was found not breathing and was pronounced deceased at 6:15 AM. This was for 1 of 3 residents reviewed for notification of change of condition. The findings included: Resident #1 was readmitted to the facility on 12/06/23. His diagnosis included type 2 diabetes mellitus (DM), anxiety, chronic congestive heart failure (CHF), and dysphagia (difficulty swallowing). Resident #1's quarterly Minimum Data Set (MDS) assessment dated 07/01/24 indicated his	F 580	Past noncompliance: no plan of correction required.	

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cognition was intact. There was no rejection of care or behaviors coded.

A Nurse Practitioner (NP) progress note dated 09/18/24 revealed Resident #1 was lying in bed with eyes closed, easily arousable and answering questions when asked. He denied shortness of breath and there was no cough observed. The note also revealed that during physical exam of Resident #1's chest/pulmonary and general/constitutional systems that no physical findings pertinent to this encounter.

An interview with Med Aide (MA) #1 was conducted on 09/25/24 at 10:40 AM. She verified she was the direct care MA for Resident #1 on 09/18/24 and she did not observe any concerns with him on first shift (7A-3P). She further stated he was talkative and did not voice any concerns.

An interview with Nurse #3 was conducted on 09/25/24 at 10:05 AM. Nurse #3 stated she cared for Resident #1 on 09/18/24 from 3:00 PM to 4:00 PM. Nurse #3 explained she was the wound care nurse however they had a call out and she was covering the assignment until Nurse #1 arrived. Nurse #3 also stated when she received report from first shift, they informed her that Resident #1 refused his medications at noon. Nurse #3 verified she did go and speak with Resident #1 at approximately 3:25 PM, and he was "fine". Nurse #3 did not observe Resident #1 with increased cough or congestion. Nurse #3 also stated she was still working assisting with meal trays and Resident #1 refused dinner on 09/18/24, however that was not a new behavior, as he refused meals

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and medications at times.

A phone interview was conducted with Nursing Assistant (NA) #1 on 09/24/24 at 3:01 PM. She verified she worked from 09/18/24 at 11:00 PM through 09/19/24 at 7:00 AM and she was the direct care NA for Resident #1. NA #1 stated she notified Nurse #1 at 2:00 AM that Resident #1's roommate had requested her to come look at Resident #1 because he did not sound good. NA #1 stated she observed Resident #1 coughing, and she could hear congestion. NA #1 also notified Nurse #1 at 3:30 AM that Resident #1 had his mouth open, and you could see phlegm in his mouth, and he was coughing. She stated Nurse #1 went to his room but did not tell her anything. NA #1 indicated she had not worked with the resident that often and she was not sure of his baseline. NA #1 explained at 5:00 AM she went in to change him and he was not breathing and had no pulse. She immediately notified Nurse #1.

A nursing progress note recorded as a late entry on 09/23/24 for 09/19/24 by Nurse #1 revealed at 4:28 AM she entered Resident #1's room and heard rales (fine crackles, are abnormal breath sounds that occur when a person inhales and sound like small clicking, bubbling, or rattling) during inspiration. She checked his vital signs which included a blood pressure (BP) of 90/86, pulse of 48, oxygen at 89% room air, and temperature of 96.1 (axillary). Resident #1 had previously refused to have continuous positive airway pressure (CPAP) on for the night. Nursing Assistant (NA) observed that Resident #1 wasn't breathing. This nurse walked down to Resident

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#1's room and also observed that he wasn't breathing. Code status was validated, and CPR initiated. EMS pronounce death 6:15 AM.

A phone interview was conducted with Nurse #1 on 09/24/24 at 11:30 AM. Nurse #1 verified she was the nurse for Resident #1 on 09/18/24 from 4:00 PM through 09/19/24 at 7:00 AM. Nurse #1 indicated she checked on Resident #1 at 4:15 PM and observed Resident #1 resting with his eyes closed, even rise and fall of chest, and no distress noted. Nurse #1 asked Resident #1 if he wanted his afternoon medication and Resident #1 shook his head no. Nurse #1 told Resident #1, she would be back later. Nurse #1 indicated she did not normally crush Resident #1's medications however she did crush his 8:00 PM medications due to him exhibiting congestion, trying to cough up clear phlegm, and difficulty swallowing. Nurse #1 verified these symptoms were not normal for Resident #1. Resident #1 did not voice any concerns at that time and Nurse #1 she did not check Resident #1's vital signs. Nurse #1 indicated she left Resident #1's room to administer other resident's medications. Nurse #1 explained she checked on Resident #1 at 10:50 PM and she could still hear audible congestion, but no difficulty breathing was observed. He was resting with eyes closed. Nurse #1 checked on Resident #1 at 2:00 AM and he was resting with eyes closed and exhibiting audible congestion. Nurse #1 stated she checked on Resident #1 again at 3:30 AM, Resident #1 had his eyes closed and did not appear to be in distress. Resident #1 had his mouth open, clear phlegm was noted in his mouth, and he was coughing which was not normal for Resident #1. She stated she did not notify the physician or Nurse

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Practitioner (NP) of the coughing, audible congestion, and phlegm. Nurse #1could not give a reason for not notifying the physician or NP. Nurse #1 explained she returned to check on Resident #1 at 4:28 AM and she could still hear the audible congestion, but no difficulty breathing or coughing was observed. Nurse #1 checked his vital signs which included: blood pressure (BP) 90/86, pulse 48, oxygen level 89% on room air, respirations 12, and his skin was clammy and "tepid". Nurse #1 removed his blanket and put a sheet on him to help cool him off because his skin was extremely hot to the touch. Resident #1 did not speak to Nurse #1 during this assessment. Nurse #1 stated she did not know why she did not notify the physician or Nurse Practitioner (NP) at that time, she said, "I just didn't". She further explained when she returned to the hall at 5:00 AM NA #1 exited Resident #1's room and stated he was not breathing.

Emergency medical services (EMS) report revealed the following: the call was received/dispatched at 6:01 AM, on scene at 6:09 AM, and at patient at 6:11 AM. Primary Impression was obvious death, at scene, emergency medical services (EMS) crew directed to Resident #1's room by facility staff. The fire department (FD) and police department (PD) were already at bedside. Per report from FD, staff reported Resident #1 was last known well (LKW) at 5:15 AM this morning. FD and law enforcement (LE) on scene reported that cardiopulmonary resuscitation (CPR) was not in progress by facility staff at their arrival. No facility staff were present at bedside. EMS crew requested a firefighter to obtain patient information and code status from facility staff. Resident #1 found to be full code on

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facility paperwork. The primary impression was obvious death. Resident #1 found supine in facility bed. Resident #1 found to be apneic (cessation of respiration) and without pulse. A 4-lead electrocardiogram (ECG) (a test that measures the heart's electrical activity) performed and noted asystole (when your heart's electrical system fails, causing your heart to stop pumping) in all pre-cordial leads. Mottling (blotchy patches of discoloration on the skin) noted in extremities and posterior of patient's trunk. Eyes non-reactive to light. Per protocol, due to extended downtime without CPR and asystole upon presentation, CPR efforts not initiated, and time of death noted at 6:15 AM.

A phone interview was conducted with the Medical Director (MD) on 09/24/24 at 3:08 PM. He stated he would have expected the staff to call him or the Nurse Practitioner (NP) when the difficulty swallowing, audible congestion, and cough were first observed. The MD had not received a call about Resident #1 having a change in condition that included swallowing difficulties, cough, congestion, or low vital signs. He also stated that it was standard practice to call the MD when a change occurs. He stated he thought the nurse deviated out of the standard practice when she did not call a NP or MD. He indicated if Resident #1's vital signs were low, and he was having difficulty breathing he would have needed to be sent to the hospital for evaluation.

An interview with the Director of Nursing (DON) was conducted on 09/25/24 at 11:18 AM. She stated Nurse #1 should have applied oxygen due

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to Resident #1's oxygen levels dropping, and she expected Nurse #1 to notify the physician for a change in condition of a resident as soon as it was observed.

The Administrator was notified of immediate jeopardy on 09/25/24 at 1:15 PM.

The facility provided the following corrective action plan with a completion date of 09/20/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 9/19/2024, Nurse #1 obtained vital signs for Resident #1 at 0428. Vital signs documented: axillary temperature 96.1, pulse 48, respirations 12, blood pressure 90/84, oxygen saturation 89% on room air. Nurse #1 identified congestion, difficulty swallowing, and the presence of phlegm on the 3p-11p shift with no follow up or ongoing monitoring. Nurse #1 failed to notify physician of Resident #1's change in condition during her shift.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 9/19/2024 all current interviewable residents were interviewed by the Director of Social Services to ensure that they felt any change in conditions were acted upon timely by the staff including physician notification and to ensure

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there were no concerns with delay or withholding of care and treatment.

On 9/19/2024 a 30 day look back of progress notes was reviewed by the Assistant Director of Nursing for current non-interviewable residents to ensure that there were no concerns related to change in condition or delay or withholding of care and treatment, including physician notification.

On 9/19/2024 all staff were interviewed by the Director of Nursing or designee to determine if there were any concerns related to delay or withholding of care related to a resident change in condition including physician notification.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 9/19/2024 the Staff Development Coordinator or designee educated all staff on care services related to identification of change in condition, providing timely treatment as ordered not withholding care, reporting any concerns and notification to physician.

The same education will be provided by the Staff Development Coordinator or designee to agency staff upon first shift worked and all new hires during orientation effective 9/19/2024 per directive of the Director of Nursing.

Change in condition identification, notification of physician, validation of timely treatment and

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follow up will be reviewed in clinical morning meeting by the Interdisciplinary Team Monday through Friday. Any negative findings will be acted upon immediately. The Interdisciplinary Team includes the Administrator,

Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Wound Nurse, Clinical Coordinator, Director of Social Services, Director of Rehabilitation, Life Enrichment Director, Dietary Manager, MDS Coordinator per the directive of the Director of Nursing on 9/19/2024.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

On 9/19/2024 it was established by the Interdisciplinary Team that beginning the week of 9/23/2024 through 11/15/2024, the following steps will be completed and documented weekly for 8 weeks.

Five interviewable residents will be interviewed weekly by the Director of Social Services or designee to ensure that resident concerns are addressed timely, that there are no unresolved concerns, that facility is respecting Resident Rights, that the facility is identifying resident changes in condition, if a resident has had a medical concern the facility has addressed it timely and notified the physician, and have no concerns that have the potential to be considered abuse/neglect.

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Five non-interviewable residents will have their medical record reviewed weekly by a clinical manager to identify any concerns related to change in condition, any delay or withholding of care or treatment, or any concerns with Resident Rights, code statuses not being honored will also be reviewed. Any concerns will be immediately addressed to include physician notification if indicated.

Five staff members will be interviewed weekly the Administrator or designee to determine if there are any concerns related to delay in identification in resident Change in Condition, delay or withholding of treatment or concerns regarding physician notification.

Facility Activity Report will be reviewed Monday through Friday in Clinical Morning Meeting to ensure timely identification of Change in Condition, notification of physician, prompt treatment if indicated, appropriate response for a resident that is a full code, timely identification of potential neglect.

The Quality Improvement Committee will review the results of the audits for further recommendation weekly for 8 weeks. Should the committee feel that further auditing is necessary, it will be determined at that time.

Above responsibilities were discussed during Ad-hoc QAPI completed on 9/19/2024.

Alleged Compliance date: 9/20/24

Date if immediate jeopardy removal is 9/20/24

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F 580	Continued From page 12 On 09/25/24 the credible allegation of Immediate Jeopardy removal was validated by onsite verification and included: The facility provided documentation to support their corrective action plan. The initial facility audits dated 09/19/24 were reviewed and revealed no issues were noted. Education to licensed nursing, nurse aides and medication aide staff regarding a change in condition was reviewed and sign in sheets were provided. Staff interviews across all departments were able to verbalize that they had received education on change in condition, examples of change in condition, and who to notify of a change in resident condition. QAPI meetings were discussed with the Administrator and meeting notes were reviewed. The facility's date of 09/20/24 for the corrective action plan was validated on 09/26/24.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		

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F 600	Continued From page 13 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and physician, Nurse Practitioner (NP), and staff interviews, the facility failed to protect a resident's right to be free from neglect when staff failed to provide necessary care and services for 1 of 3 residents reviewed for neglect. Resident #1 had a significant change in condition on 09/18/24 and the nurse did not recognize the seriousness, notify the physician or provide thorough and ongoing assessments. In addition, Resident #1 was found not breathing and without a pulse on 09/19/24 and Cardiopulmonary Resuscitation (CPR) was not immediately administered. Resident #1 was pronounced deceased by emergency medical services (EMS) on 9/19/24. This was for 1 of 3 residents reviewed for neglect (Resident #1). The findings included: This citation is cross referred to: 1. F580 Based on record review, and staff and Medical Director (MD) interviews, the facility failed to notify the physician for a resident who had a significant change in condition. On 09/18/24 Resident #1 was observed with audible congestion, difficulty swallowing, and was trying to cough up phlegm. The MD or Nurse Practitioner (NP) were not notified. On 09/19/24 Resident #1 had his mouth open with clear phlegm noted in his mouth and he was coughing. Resident #1 ' s vital signs included a blood	F 600	Past noncompliance: no plan of correction required.	

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pressure (BP) of 90/86 (normal 120/80), pulse of 48 (normal range 60-100), oxygen at 89% (normal range between 95% and 100%) on room air, and respirations of 12 (normal range 12-18). He had audible congestion, and his skin was extremely hot to touch. The MD or Nurse Practitioner (NP) were not notified. At 5:00 AM Resident #1 was found not breathing and was pronounced deceased at 6:15 AM. This was for 1 of 3 residents reviewed for notification of change of condition.

2. F678

Based on observation, record review, and staff, and Nurse Practitioner (NP) interviews the facility failed to ensure that Cardiopulmonary Resuscitation (CPR) was administered immediately and failed to operationalize an effective system so staff could respond to an emergency situation as needed. On 9/19/24 Nurse #1 was notified that Resident #1 was unresponsive, not breathing and had no pulse. Nurse #1 verified Resident #1 was not breathing. Nurse #1 did not verify Resident # s code status and resumed her nursing duties on another hall. Nurse #1 was later informed that Resident #1 was a full code, Nurse #1 then started CPR without initiating a "code blue protocol." Nurse #1 stopped CPR when she became tired. Resident #1 was pronounced deceased by emergency medical services (EMS) on 9/19/24. This was for 1 of 3 residents reviewed for CPR (Resident #1).

3. F684

Based on record review, staff interviews, Nurse

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Practitioner (NP) and Medical Director (MD) interviews, the facility failed to provide complete, thorough, and ongoing assessments, and failed to intervene when Nurse #1 failed to recognize the seriousness of a resident ' s (Resident #1) change in condition. Resident #1, who was a full code, was experiencing a change in condition on 09/18/24 with symptoms of difficulty swallowing, audible congestion (able to hear without the use of stethoscope), and trying to cough up phlegm. Nurse #1 did not obtain vital signs or put interventions into place to relieve the congestion. On 09/19/24 Resident #1 had his mouth open, clear phlegm was noted in his mouth, audible congestion continued, and he was coughing. Resident #1's vital signs, which included a blood pressure (BP) of 90/86 (normal 120/80), pulse of 48 (normal range 60-100), oxygen saturation at 89% (normal range between 95% and 100%) on room air, respirations 12 (normal range 12-18), and temperature 96.7 (axillary/arm pit). Nurse #1 did not obtain another set of vital signs, and at 5:00 AM when Resident #1 was discovered with no pulse. Nurse #1, who did not verify Resident #1's full code status, did not initiate lifesaving resuscitative efforts and returned to administering medications. At 5:55 AM when Nurse #1 became aware of Resident #1's full code status, she initiated Cardiopulmonary Resuscitation (CPR). Emergency medical services (EMS) were called at 6:00 AM, arrived at 6:10 AM, and Resident #1 was pronounced deceased at 6:15 AM. This was for 1 of 3 residents reviewed for change of condition.

An interview with the Director of Nursing (DON) was conducted on 09/25/24 at 11:18 AM. The DON stated she did not feel the failure to monitor,

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assess, call the physician when a change of condition was observed, not checking Resident #1's code status and not initiating CPR was neglect but a lack of nursing competency of Nurse #1. She indicated Nurse #1 should have notified the physician, should have been obtaining vital signs and monitoring Resident #1 throughout the shift. The DON further also expected Nurse #1 to notify the physician of a change in condition of a resident as soon as it was observed and to verify a resident's code status immediately if found without a pulse.

The Administrator was notified of immediate jeopardy on 09/25/24 at 1:15 PM.

The facility provided the following corrective action plan with a completion date of 09/20/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 9/19/2024 Nurse #1 failed to notify physician of change in condition of Resident #1. Nurse #1 failed to monitor Resident #1 ' s change in condition. Nurse #1 failed to verify Resident #1's code status and failed to initiate CPR for Resident #1 with Advanced Directive of Full Code. Nurse #1 neglected to honor Resident #1's rights.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

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On 9/19/2024 Director of Social Services interviewed all alert and oriented residents to ensure they felt their rights were honored; change in conditions were acted upon timely by the staff and to ensure there were no concerns with delay or withholding of care and treatment.

On 9/19/2024 Medical records were reviewed by the Assistant Director of Nursing for current non-verbal residents to identify any concerns related to change in condition or delay or withholding of care.

On 9/19/2024 All staff were interviewed by Director of Nursing or designee to determine if there were any concerns related to delay or withholding of care or identification of resident change in condition and treatment, violation of resident rights, or concerns with any code status not being provided as ordered.

On 9/19/2024 A record review of the last 30 days of deaths was audited by the Director of Nursing. There were no deaths or change in condition identified that required Cardiopulmonary Resuscitation.

On 9/19/2024 crash carts were audited to ensure that all appropriate equipment is on the cart and in working condition.

On 9/19/2024 the wound nurse completed a full facility review of all code status orders and care plans to ensure there were no concerns, no discrepancies noted.

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On 9/19/2024 the Staff Development Coordinator reviewed employee files for licensed staff to ensure they have up to date CPR certification to include licensed staff present at the time of the event.

On 9/19/2024 Nurse #1's agency was notified of event to review her employee file for any previous issues or disciplinary action. The Director of Compliance & Client Services of Convergence Medical Staffing validated no previous issues or disciplinary action documented.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 9/19/2024 the Staff Development Coordinator or designee educated all staff on care services related to identification of change in condition, providing timely treatment as ordered not withholding care, facility CPR policy, honoring resident rights, reporting any concerns immediately, Abuse policy and procedures with a special focus on neglect.

The same education will be provided by the Staff Development Coordinator or designee to agency staff upon first shift worked and all new hires during orientation effective 9/19/2024 per directive of the Director of Nursing.

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On 9/19/2024, mock codes were conducted across all shifts by the Staff Development Coordinator with nursing department staff. Nursing department staff includes Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides.

On 9/19/2024 Change in condition identification, notification of physician, validation of timely treatment, follow up, appropriate code response, concerns of resident right violations and any potential abuse will be reviewed in clinical morning meeting Monday through Friday. Any negative findings will be acted upon immediately.

On 9/19/2024 Routine resident council will be held by the facility leadership routinely but no less than monthly. Resident Rights will be reviewed. Any concerns will be addressed by the appropriate department manager.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

On 9/19/2024 it was established by the Interdisciplinary Team that beginning the week of 9/23/2024 through 11/15/2024, the following steps will be completed and documented weekly for 8 weeks.

Director of Life Enrichment or designee will conduct and follow up on a weekly Resident Council meeting to ensure that resident concerns are addressed timely, that there are no

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unresolved concerns, that facility is respecting Resident Rights, that the facility is identifying resident changes in condition and if a resident has had a medical concern, has the facility addressed it timely.

Five interviewable residents will be interviewed weekly by the Director of Social Services or designee to ensure that resident concerns are addressed timely, that there are no unresolved concerns, that facility is respecting Resident Rights, that the facility is identifying resident changes in condition, if a resident has had a medical concern the facility has addressed it timely, and have no concerns that have the potential to be considered abuse/neglect.

Five non-interviewable residents will have their medical record reviewed weekly by a clinical manager to identify any concerns related to change in condition, any delay or withholding of care or treatment, or any concerns with Resident Rights, code statuses not being honored will also be reviewed.

Five staff members will be interviewed weekly the Administrator or designee to determine if there are any concerns related to delay in identification in resident Change in Condition, delay or withholding of treatment, violation of Resident Rights, or concerns with code status not being provided as ordered.

All resident deaths or code activity will be reviewed by the clinical team to ensure the resident ' s code status was carried out by staff without delay.

Mock codes will be conducted one random shift

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per week by the Director of Nursing or designee across all shifts to ensure timely and appropriate response. Any identified concerns will be addressed immediately.

Crash carts will be audited daily by the Assistant Director of Nursing or designee to ensure that appropriate equipment is present.

Facility Activity Report will be reviewed Monday through Friday in Clinical Morning Meeting to ensure timely identification of Change in Condition, notification of physician, prompt treatment if indicated, appropriate response for a resident that is a full code, timely identification of potential neglect.

The Quality Improvement Committee will review the results of the audits for further recommendation weekly for 8 weeks. Should the committee feel that further auditing is necessary, it will be determined at that time.

Above responsibilities were discussed during Ad-hoc QAPI completed on 9/19/2024.

Alleged Compliance date: 9/20/24

Date of immediate jeopardy removal is 9/20/24

On 09/25/24 the credible allegation of Immediate Jeopardy removal was validated by onsite verification and included:

The facility provided documentation to support their corrective action plan. The initial facility audits dated 09/19/24 were reviewed and revealed no issues were noted. Education to

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F 600	Continued From page 22 licensed nursing, nurse aides and medication aide staff regarding a change in condition was reviewed and sign in sheets were provided. Staff interviews across all departments were able to verbalize they had received education on change in condition, examples of change in condition, and who to notify in the event of a change in condition of a resident. Quality Assurance and Performance Improvement (QAPI) meetings were discussed with the Administrator and meeting notes were reviewed. The facility's compliance date of 09/20/24 for the corrective action plan was validated on 09/26/24.	F 600		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and Nurse Practitioner (NP) interviews the facility failed to ensure that Cardiopulmonary Resuscitation (CPR) was administered immediately and failed to operationalize an effective system so staff could respond to an emergency situation as needed. On 9/19/24 Nurse #1 was notified that Resident #1 was unresponsive, not breathing and had no pulse. Nurse #1 verified Resident #1 was not breathing. Nurse #1 did not verify Resident #1's code status and resumed her nursing duties on another hall.	F 678	Past noncompliance: no plan of correction required.	

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Nurse #1 was later informed that Resident #1 was a full code, Nurse #1 then started CPR without initiating a "code blue protocol." Nurse #1 stopped CPR when she became tired. Resident #1 was pronounced deceased by emergency medical services (EMS) on 9/19/24. This was for 1 of 3 residents reviewed for CPR (Resident #1).

The findings included:

Review of the facility's CPR policy revised October 2023 indicated the following:

Activate the emergency response team:

The resident should not be left alone.

If you are alone with the victim, call out for help.

If someone is nearby, instruct them to dial 911 immediately.

In the event help is not available, call 911 and retrieve emergency cart prior to starting CPR, return as soon as possible.

Use an AED as soon as possible if one is available. If no AED is available, continue the cycle of compressions: Breaths for about two minutes then recheck pulse and continue if none noted.

Continue CPR efforts until pulse is restored, EMS arrives, an onsite physician or nurse practitioner instructs otherwise, or until the team can no longer continue due to exhaustion.

Resident #1 was readmitted to the facility on 12/06/23. His diagnosis included type 2 diabetes

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mellitus (DM), anxiety, chronic congestive heart failure (CHF), and dysphagia (difficulty swallowing).

A physician order dated 03/23/24 indicated Resident #1 was a full code.

Chart review did not reveal a Medical Orders for Scope of Treatment (MOST) form (a legal document that allows patients to outline their treatment preferences and end-of-life care. No MOST form indicates that a resident wishes the full scope of treatment for saving their life) for Resident #1.

Resident #1's care plan, last reviewed/revised on 07/17/24, revealed a focus that read: Category: Advanced Directives/Code Status Resident #1 has chosen full code status

A nursing progress note written 09/19/24 at 5:33 AM by Nurse #1 revealed "Resident #1expired at 5:00 AM."

A nursing progress note recorded as a late entry on 09/23/24 for 09/19/24 by Nurse #1 read: This nurse did resident rounding at 4:28 AM on the 800 hall before starting medication pass on the 200 hall. Walked in Resident #1 ' s room and heard rales (abnormal rattling sound in the lungs) during inspiration. This nurse checked vitals BP:90/84, P:48, R:12, O2: 89% room air, T:96.1 (auxiliary) resident previously refused to have CPAP place on for the night. NA started her resident rounding at the bottom of the 800 hall. NA observed that Resident #1 wasn't breathing. This nurse walked down to Resident #1's room and also observed that patient wasn't breathing. Code status was validated, and CPR initiated.

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EMS pronounce death 6:15 AM. Postmortem care done.

A phone interview was conducted with Nurse #1 on 09/24/24 at 11:30 AM. Nurse #1 verified she was the nurse for Resident #1 on 09/18/24 from 4:00 PM through 09/19/24 at 7:00 AM. She explained at 5:00 AM Nursing Assistant (NA) #1 was exiting Resident #1's room and stated he was not breathing. She stated she told NA #1 she knew it was coming because his vital signs were sitting low at 4:28 AM. Nurse #1 verified she did not check his code status at 5:00 AM. She also stated, "I don't know why I didn't check his code status, I thought he was a Do Not Resuscitate (DNR)". She explained she was informed at 5:55 AM by NA #2 that Resident #1 was a full code. NA # 2 proceeded to the nurses' station to call 911 and Nurse #1 started CPR, however she stopped CPR a short time later to retrieve the crash cart. When Nurse #1 returned to Resident #1, she put the back board under him and resumed CPR at approximately 6:00 AM. She stated Resident #1's body was warm to the touch. NA #2 returned to Resident #1's room and Nurse #1 told her she did not have anything on the crash cart to do CPR such as an AED, oxygen, tubing, or a suction machine. Nurse #1verified she did not ask for assistance from other staff members, nor did she activate the code blue protocol. She explained she stopped performing CPR at 6:06 AM because she was tired. Law enforcement arrived at 6:08 AM and then emergency medical services (EMS) arrived at 6:10 AM. Resident #1 was pronounced deceased at 6:15 AM by EMS. She further stated when she wrote the nursing note on 09/23/24 for the events that occurred on 09/19/24 she did not add the times that she verified Resident #1 did not have a

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pulse or what time she started CPR. Nurse #1 indicated she did not know why she thought Resident #1 was a DNR, she just assumed he was.

A phone interview was conducted with Nursing Assistant (NA) #1 on 09/24/24 at 3:01 PM. NA #1 explained that at 5:00 AM on 09/19/24 she went in to change Resident #1, he was warm to the touch, however he was unresponsive, not breathing and had no pulse. NA #1 immediately notified Nurse #1. NA #1 stated Nurse #1 said she figured it was coming due to his vital signs being low earlier. NA #1 observed Nurse #1 check for Resident #1's pulse and the rise and fall of his chest which were absent. Nurse #1 verified Resident #1 was not breathing. NA #1 stated that Nurse #1 did not start cardiopulmonary resuscitation (CPR) and she went to another hall to pass medications. NA #1 explained she provided postmortem care to Resident #1. NA #1 further stated at approximately 5:55 AM she informed Nurse #2 that Resident #1 had passed away.

A phone interview was conducted with Nurse #2 on 09/24/24 at 2:54 PM. Nurse #2 stated she was coming up the 100 hall when she was approached at 5:55 AM by Nursing Assistant (NA) #1 and was told that Resident #1 had passed away. Nurse #2 explained that after she had spoken to NA #1, she was at the nurses' station on the 100/300 hundred hall and she informed NA #2 that Resident #1 had passed away. Nurse #2 stated NA #2 jumped up and said, "oh my god he's a full code," as she went towards the main nursing station to check the code status binder. Between 6:02 AM and 6:06 AM she went to the 800 hall to see if Nurse #1 needed help and

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Nurse #1 stated no, she did not need help and emergency medical services (EMS) were on the way. Nurse #2 went back to the 100/300 hall to check on her residents then went back to the 800 hall. Nurse #2 explained she went back to the 100/300 hall for two or three minutes then went to Resident #1's room at approximately 6:08 AM, law enforcement and first responders were in the room. At that time EMS was at the side door of the building. Nurse #2 recalled Nurse #1 was talking to law enforcement, and she went to make copies of Resident #1's paperwork. She further stated Nurse #1 did not call the code overhead when she was made aware of his code status. Nurse #2 confirmed she did not observe Nurse #1 perform CPR at any time.

An interview was conducted with Nursing Assistant (NA) #2 on 09/24/24 at 11:44 AM. NA #2 verified she worked on 09/18/24 from 11:00 PM through 09/19/24 at 7:00 AM on the 100/300 halls. NA #2 stated she was sitting at the nursing station when Nurse #2 told her Resident #1 had passed away. She explained that she jumped up and said, "oh my god, he's a full code", as she went up the hall towards the main nursing station. She looked in the Do Not Resituate (DNR) binder and removed Resident #1's sheet that indicated he was a full code. NA #2 then stated she took that sheet to Nurse #1 which was halfway down the 800 hall to show her Resident #1 was a full code. She explained that Nurse #1 stated several times, "you've got to be kidding me". NA #2 told Nurse #1 to grab the crash cart, and she would call 911. NA # 2 proceeded to the nurse station to call 911. After the call was completed, she went to Resident #1's room where Nurse #1 was going through the drawers of the crash cart saying she didn't have anything to do CPR with such as an

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automated external defibrillator (AED), oxygen, tubing, or a suction machine. NA #2 stated the ambu-bag was located on the side of the crash cart unopened, it appeared that the backboard was under Resident #1's back and she reminded Nurse #1 the oxygen tank was located beside the crash cart. She looked up and saw law enforcement and the first responders coming up the hall. She indicated she then went back to her assignment. She was unaware Nurse #1 initiated CPR prior to grabbing the crash cart. NA #2 explained that she also did medical records at the facility and that was how she was aware of Resident #1's code status.

Emergency medical services (EMS) report revealed the following: the call was received/dispatched at 6:01 AM, on scene at 6:09 AM, and at patient at 6:11 AM. Primary Impression was obvious death, at scene, emergency medical services (EMS) crew directed to Resident #1's room by facility staff. The fire department (FD) and police department (PD) were already at bedside. Per report from FD, staff reported Resident #1 was last known well at 5:15 AM this morning. FD and law enforcement on scene reported that cardiopulmonary resuscitation (CPR) was not in progress by facility staff at their arrival. No facility staff were present at bedside. EMS crew requested a firefighter to obtain patient information and code status from facility staff. Resident #1 found to be full code on facility paperwork. The primary impression was obvious death. Resident #1 found supine in facility bed. Resident #1 found to be apneic (cessation of respiration) and without pulse. A 4-lead electrocardiogram (ECG) (a test that measures the heart's electrical activity) performed and noted asystole (when your heart's electrical

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system fails, causing your heart to stop pumping) in all pre-cordial leads. Mottling (blotchy patches of discoloration on the skin) noted in extremities and posterior of patient's trunk. Eyes non-reactive to light. Per protocol, due to extended downtime without CPR and asystole upon presentation, CPR efforts not initiated, and time of death noted at 6:15 AM.

A phone interview was conducted with the Nurse Practitioner (NP) on 09/24/24 at 4:00 PM. He stated he would expect the nurse to verify code status immediately if a resident was observed with no pulse. The NP stated he could not speculate and say that if CPR was immediately initiated that Resident #1's outcome would have been different.

An interview with the Director of Nursing (DON) was conducted on 09/25/24 at 11:18 AM. She stated Nurse #1 should have checked Resident #1's code status when she observed increased congestion, change in his oxygen levels, and immediately after verifying, he was without a pulse. She also stated everything was on the crash cart that the facility keeps on it and the oxygen is located right beside the crash cart. The facility does not utilize an AED.

The Administrator was notified of immediate jeopardy on 9/25/24 at 1:15 PM.

The facility provided the following corrective action plan with a completion date of 09/20/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

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On 9/19/2024 at 0500, NA #1 notified Nurse #1 that Resident #1 was unresponsive. Nurse #1 failed to verify Resident #1's code status and failed to initiate Cardiopulmonary Resuscitation timely.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 9/19/2024, a record review of the last 30 days of deaths was audited by the Director of Nursing. There were no deaths or change in condition identified that required Cardiopulmonary Resuscitation.

On 9/19/2024, crash carts were audited by the wound nurse to ensure that all appropriate equipment is on the cart and in working condition.

On 9/19/2024, the wound nurse completed a full facility review of all code status orders and care plans to ensure there were no concerns, no discrepancies noted.

On 9/19/2024, the Staff Development Coordinator reviewed employee files for licensed staff to ensure they have up to date CPR certification to include licensed staff present at the time of the event.

Address what measures will be put into place or systemic changes made to ensure that the

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deficient practice will not recur:

On 9/19/2024 the Staff Development Coordinator or designee educated all staff on the facility Cardiopulmonary Resuscitation Policy.

The same education will be provided by the Staff Development Coordinator or designee to agency staff upon first shift worked and all new hires during orientation effective 9/19/2024 per directive of the Director of Nursing.

On 9/19/2024, mock codes were conducted across all shifts by the Staff Development Coordinator with nursing department staff. Nursing department staff includes Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides.

Routine crash cart audits will be completed daily by a member of the Interdisciplinary Team effective 9/23/2024 per the Administrator. The Interdisciplinary Team includes Medical Records Coordinator, Director of Social Services, Life Enrichment Director, Director of Environmental Services, Food Service Director, Administrator, Business Office Coordinator, and Central Supply Manager. These members of the Interdisciplinary Team have been educated on crash cart equipment compliance per the Administrator and Director of Nursing.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

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On 9/19/2024 it was established by the Interdisciplinary Team that beginning the week of 9/23/2024 through 11/15/2024, the following steps will be completed and documented weekly for 8 weeks.

Mock code audits will be conducted one random shift per week by the Director of Nursing or designee across all shifts to ensure timely and appropriate response. Any identified concerns will be addressed immediately.

Crash carts will be audited daily by the Assistant Director of Nursing or designee to ensure that appropriate equipment is present.

The Quality Improvement Committee will review the results of the audits for further recommendation weekly for 8 weeks. Should the committee feel that further auditing is necessary, it will be determined at that time.

Above responsibilities were discussed during Ad-hoc QAPI completed on 9/19/2024.

Alleged Compliance date: 9/20/24

Date of immediate jeopardy removal is 9/20/24

On 09/25/24 the credible allegation of Immediate Jeopardy removal was validated by onsite verification and included:

The facility provided documentation to support their corrective action plan. The initial facility audits dated 09/19/24 were reviewed and

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F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner (NP) and Medical Director (MD) interviews the facility failed to provide complete, thorough, and ongoing assessments, and failed to intervene when Nurse #1 failed to recognize the seriousness of a resident's (Resident #1) change in condition. Resident #1, who was a full	F 684	Past noncompliance: no plan of correction required.	

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code, was experiencing a change in condition on 09/18/24 with symptoms of difficulty swallowing, audible congestion (able to hear without the use of stethoscope), and trying to cough up phlegm. Nurse #1 did not obtain vital signs or put interventions into place to relieve the congestion. On 09/19/24 Resident #1 had his mouth open, clear phlegm was noted in his mouth, audible congestion continued, and he was coughing. Resident #1's vital signs, which included a blood pressure (BP) of 90/86 (normal 120/80), pulse of 48 (normal range 60-100), oxygen saturation at 89% (normal range between 95% and 100%) on room air, respirations 12 (normal range 12-18), and temperature 96.7 (axillary/arm pit). Nurse #1 did not obtain another set of vital signs, and at 5:00 AM when Resident #1 was discovered with no pulse. Nurse #1, who did not verify Resident #1's full code status, did not initiate lifesaving resuscitative efforts and returned to administering medications. At 5:55 AM when Nurse #1 became aware of Resident #1's full code status, she initiated Cardiopulmonary Resuscitation (CPR). Emergency medical services (EMS) were called at 6:00 AM, arrived at 6:10 AM, and Resident #1 was pronounced deceased at 6:15 AM. This was for 1 of 3 residents reviewed for change of condition (Resident #1).

The findings included:

Resident #1 was readmitted to the facility on 12/06/23. His diagnosis included type 2 diabetes mellitus (DM), anxiety, chronic congestive heart failure (CHF), and dysphagia (difficulty swallowing).

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A physician order dated 03/23/24 indicated Resident #1 was a full code.

A physician order dated 08/21/24 to apply Bi-pap (Bilateral Positive Airway Pressure-a noninvasive breathing machine that helps people breathe by delivering pressurized air into their airways) every HS (hour of sleep) and remove in the morning. Note if resident does not wear.

Chart review did not reveal a Medical Orders for Scope of Treatment (MOST) form for Resident #1.

Resident #1's quarterly Minimum Data Set (MDS) assessment dated 07/01/24 indicated his cognition was intact without behaviors. There was no rejection of care or behaviors coded.

Resident #1's care plan, last reviewed/revised on 07/17/24, revealed a focus that read he had the potential for altered respiratory status/difficulty breathing related to a history of respiratory failure. The interventions included for staff to assess/document/report abnormal breathing patterns to physician, elevate head of bed to facilitate breathing per resident comfort level, as needed, and provide oxygen as ordered. Another focus read Resident #1 was at risk for complications related to vascular congestion and was on diuretic therapy which placed him at risk for adverse effects due to medication use. The interventions included for staff to administer medication as ordered and monitor for possible side effects such as dizziness, postural hypotension, fatigue, and an increased risk for falls. Notify physician as needed. A focus that read: Category: Advanced Directives/Code Status Resident #1 had chosen full code status. The

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interventions included for staff to notify physician of any changes, as needed, and if resident /responsible party chooses to change code status, necessary protocol will be completed: new order, update documentation/care plan, face sheet/identifying tool.

Note by the Nurse Practitioner (NP) dated 09/18/24 revealed Resident #1 was lying in bed with eyes closed, easily arousable and answering questions when asked. He denied shortness of breath and there was no cough observed. The note also revealed that during physical exam of Resident #1's chest/pulmonary and general/constitutional systems that no physical findings pertinent to this encounter.

An interview with Medication Aide (MA) #1 was conducted on 09/25/24 at 10:40 AM. MA #1 verified she was the direct care MA for Resident #1 on 09/18/24 and MA #1 did not observe any concerns with him on first shift (7A-3P). She further stated he was talkative and did not voice any concerns.

Review of medication administration record (MAR) for medications received on 09/18/24 and 09/19/24. 09/18/24-refused all 5:00 PM medications. All 8:00 PM medications were signed as being administered. No medications were documented as having been administered on 09/19/24. Treatment administration record (TAR) for refusing Bi-PAP on 09/10/24, 09/13/24, 09/14/24 and 09/18/24.

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An interview with Nurse #3 was conducted on 09/25/24 at 10:05 AM. Nurse #3 stated she cared for Resident #1 on 09/18/24 from 3:00 PM to 4:00 PM. Nurse #3 explained she was the wound care nurse however the facility had a call out and she was covering the assignment until Nurse #1 arrived. Nurse #3 also stated when she received report from first shift. Nurse #3 verified she did go and speak with Resident #1 at approximately 3:25 PM, and he was "fine." Nurse #3 did not observe Resident #1 with increased cough or congestion. Nurse #3 also stated she was still working assisting with meals and Resident #1 refused dinner, however that was not a new behavior, he refused meals and medications at times.

A nursing progress note recorded as a late entry on 09/23/24 for 09/19/24 by Nurse #1 read: This nurse did patient rounding at 4:28 AM on 800 hall before starting medication pass on 200 hall. Walked in Resident #1's room and heard rales (abnormal breath sounds that occur when a person inhales and sound like small clicking, bubbling, or rattling) during inspiration. This nurse checked vitals BP:90/84, P:48, R:12, O2: 89% room air, T:96.1 (axillary) patient previously refused to have CPAP place on for the night. CNA (Certified Nursing Assistant) started her pt. (patient) rounding at the bottom of the eight hundred hall. CNA observed that pt. (Resident #1) wasn't breathing. This nurse walked down to the resident's room and also observed that patient wasn ' t breathing. Code status was validated, and CPR initiated. EMS pronounce death at 6:15 AM. Postmortem care done.

A phone interview was conducted with Nurse #1 on 09/24/24 at 11:30 AM. Nurse #1 verified she

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was the nurse for Resident #1 on 09/18/24 from 4:00 PM through 09/19/24 at 7:00 AM. Nurse #1 indicated she checked on Resident #1 at 4:15 PM and observed Resident #1 resting with his eyes closed, even rise and fall of chest, and no distress noted. Nurse #1 asked Resident #1 if he wanted his afternoon medication and Resident #1 shook his head no. Nurse #1 indicated she normally did not crush Resident #1's medications, however she did crush his 8:00 PM medications due to him exhibiting congestion, trying to cough up clear phlegm, and difficulty swallowing. Nurse #1 stated the symptoms she observed when administering Resident #1 his 8:00 PM medications were abnormal for Resident #1. She said Resident #1 did not voice any concerns at that time and she did not check Resident #1's vital signs. Nurse #1 indicated she left Resident #1's room to administer other residents their medications. Nurse #1 explained she checked on Resident #1 at 10:50 PM and she could still hear audible congestion, but no difficulty breathing was observed such as gasping. He was resting with his eyes closed. Nurse #1 checked on Resident #1 at 2:00 AM and he was resting with his eyes closed and continued to exhibit audible congestion. Nurse #1 stated she checked on Resident #1 again at 3:30 AM, Resident #1 had his eyes closed and did not appear to be in distress. Nurse #1 described Resident #1 as having had his mouth open, clear phlegm was noted in his mouth, and he was coughing which was not normal for Resident #1. She stated she did not notify the physician or Nurse Practitioner (NP) of the coughing, audible congestion, and phlegm. Nurse #1could not give a reason for not notifying the physician or NP. Nurse #1 explained she returned to check on Resident #1 at 4:28 AM and she could still hear the audible congestion,

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but no difficulty breathing or coughing was observed such as gasping. Nurse #1 checked his vital signs which included: blood pressure (BP) 90/84, pulse 48, oxygen level 89% on room air, respirations 12, and his skin was clammy and "tepid." Nurse #1 removed his blanket and put a sheet on him to help cool him off because his skin was extremely hot to the touch. Resident #1 did not speak to Nurse #1 during this assessment, and she believed he was asleep. Nurse #1 stated she did not know why she did not notify the physician or Nurse Practitioner (NP) at that time about Resident #1's coughing, audible congestion, and low vital signs, she said, "I just didn't." She further explained when she returned to the 800 hall from passing medications on the 200 hall at 5:00 AM NA #1 exited Resident #1's room and stated he was not breathing. Nurse #1 checked for Resident #1's pulse and the rise and fall of his chest which were absent. Nurse #1 verified Resident #1 was not breathing.

A phone interview was conducted with Nursing Assistant (NA) #1 on 09/24/24 at 3:01 PM. She verified she worked from 09/18/24 at 11:00 PM through 09/19/24 at 7:00 AM and she was the direct care NA for Resident #1. NA #1 stated she notified Nurse #1 at 2:00 AM that Resident #1's roommate had requested her to come look at Resident #1 because he did not sound good. NA #1 stated she observed Resident #1 coughing, and she could hear congestion. NA #1 notified Nurse #1 again at 3:30 AM about Resident #1 having had his mouth open, phlegm was visible in his mouth, he was coughing, and she went and told the nurse immediately. She stated Nurse #1 went to his room but did not tell her anything. NA #1 indicated she had not worked with the resident

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that often and she was not sure of his baseline. NA #1 explained at 5:00 AM she went in to change him and he was not breathing and had no pulse. She immediately notified Nurse #1.

Resident #1's roommate was not able to be interviewed.

A phone interview was conducted with Nurse #2 on 09/24/24 at 2:54 PM. Nurse #2 stated she was coming up the 100 hall when she was approached at 5:55 AM by Nursing Assistant (NA) #1 and was told that Resident #1 had passed away. Nurse #2 explained that after she had spoken to NA #1, she was at the nurses' station on 100/300 hall with NA #2, and she informed NA #2 that Resident #1 had passed away. Nurse #2 stated NA #2 jumped up and said, "Oh my god he's a full code," as NA #2 went towards the main nursing station. Nurse #2 then stated NA #2 checked the code status binder that was located at the 800 nurses' station and verified Resident #1 was a full code. Between 6:02 AM and 6:06 AM she went to the 800 hall to see if Nurse #1 needed help and Nurse #1 stated no, she did not need help and emergency medical services (EMS) were on the way. Nurse #2 went back to the 100/300 hall to check on her residents then went back to the 800 hall. Nurse #2 then explained the crash cart was on the hall in front of Resident #1's room and law enforcement, first responders, and fire department were in the room assessing Resident #1, Resident #1 was not receiving CPR. At that time EMS was at the side door of the building. Nurse #2 recalled Nurse #1 was talking to law enforcement, and she went to make copies of Resident #1's paperwork. She further stated Nurse #1 did not call the code overhead when she was made aware of Resident

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#1's code status.

An interview was conducted with Nursing Assistant (NA) #2 on 09/24/24 at 11:44 AM. She verified she worked on 09/18/24 from 11:00 PM through 09/19/24 at 7:00 AM on the 100/300 hall, not the hall where Resident #1 resided. NA #2 stated she was sitting at the nursing station when Nurse #2 told NA #2 Resident #1 had passed away. NA #2 explained she jumped up and said, "oh my god, he's a full code," as NA #2 went up the hall towards the main nursing station. NA #2 said she looked in the Do Not Resituate (DNR) binder and removed Resident #1's sheet that indicated he was a full code. NA #2 then stated she took that sheet to Nurse #1 who was halfway down the 800 hall to show her Resident #1 was a full code. NA #2 explained that Nurse #1 stated several times, "you've got to be kidding me." NA #2 told Nurse #1 to grab the crash cart, and NA #2 went to call 911. NA # 2 proceeded to the nurses' station to call 911. NA #2 explained she is responsible for medical records at the facility, and she was an NA, that was how she was aware of Resident #1's code status. NA # 2 stated she had not been assigned to Resident #1 at all from 9/18/24 to 9/19/24.

Emergency medical services (EMS) report revealed the following: the call was received/dispatched at 6:01 AM, on scene at 6:09 AM, and at patient at 6:11 AM. Primary Impression was obvious death, at scene, emergency medical services (EMS) crew directed to Resident #1's room by facility staff. The fire department (FD) and police department (PD) were already at bedside. Per report from FD, staff reported Resident #1 was last known well (LKW) at 5:15 AM this morning. FD and law enforcement

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(LE) on scene reported that cardiopulmonary resuscitation (CPR) was not in progress by facility staff at their arrival. No facility staff were present at bedside. EMS crew requested a firefighter to obtain patient information and code status from facility staff. Resident #1 found to be full code on facility paperwork. The primary impression was obvious death. Resident #1 found supine in facility bed. Resident #1 found to be apneic (cessation of respiration) and without pulse. A 4-lead electrocardiogram (ECG) (a test that measures the heart's electrical activity) performed and noted asystole (when your heart's electrical system fails, causing your heart to stop pumping) in all pre-cordial leads. Mottling (blotchy patches of discoloration on the skin) noted in extremities and posterior of patient's trunk. Eyes non-reactive to light. Per protocol, due to extended downtime without CPR and asystole upon presentation, CPR efforts not initiated, and time of death noted at 6:15 AM.

A phone interview was conducted with the Medical Director (MD) on 09/24/24 at 3:08 PM. He stated he would have expected the staff to obtain vital signs and to call him or the NP when the difficulty swallowing, audible congestion, and cough were first observed. The MD had not received a call about Resident #1 having a change in condition that included swallowing difficulties, cough, congestion, or low vital signs. He also stated that it was standard practice to call the MD when a change occurs. He stated he thought the nurse deviated out of the standard practice when she did not call a NP or MD. He indicated if his vital signs were low, and he was having difficulty breathing he would have needed to be sent to the hospital for evaluation.

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A phone interview was conducted with the Nurse Practitioner (NP) on 09/24/24 at 4:00 PM. He stated he saw Resident #1 on 09/18/24 and he seemed to be in his normal state, alert and oriented to per, place, and time. He also stated he observed the resident as having no cough or shortness of breath. He indicated staff should have obtained vital signs and monitored Resident #1 and he would have expected the staff to call him or the Medical Director (MD) when the difficulty swallowing, audible congestion, and cough were first observed.

An interview with the Director of Nursing (DON) was conducted on 09/25/24 at 11:18 AM. She stated Nurse #1 should have applied oxygen due to Resident #1's oxygen levels dropping, she should have notified the physician, and she should have been obtaining vital signs throughout the shift. She also expected Nurse #1 to notify the physician for a change in condition of a resident as soon as it was observed.

On 09/25/24 at 1:15 PM the Administrator and DON were made aware of the Immediate Jeopardy.

The facility implemented the following corrective action plan with a completion date of 09/20/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 09/19/24, Resident #1 was noted with abnormal vital signs at 4:28 AM per Nurse #1. Nurse #1 identified congestion, difficulty swallowing, and the presence of phlegm on the

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3-11p shift with no follow up or ongoing monitoring. Nurse #1 failed to further assess Resident #1's change in condition or implement interventions to improve Resident #1's condition.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 09/19/24 all current interviewable residents were interviewed by the Director of Social Services to ensure that they felt any change in conditions were acted upon timely by the staff including physician notification and to ensure there were no concerns with delay or withholding of care and treatment.

On 09/19/24 a 30 day look back of progress notes was reviewed by the Assistant Director of Nursing for current non-interviewable residents to ensure that there were no concerns related to change in condition or delay or withholding of care and treatment, including physician notification.

On 09/19/24 all staff were interviewed by the Director of Nursing or designee to determine if there were any concerns related to delay or withholding of care related to a resident change in condition including physician notification.

On 09/19/24 a record review of the last 30 days of deaths was audited by the Director of Nursing. There was no change in condition identified that required Cardiopulmonary Resuscitation.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

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On 09/19/24 the Staff Development Coordinator or designee educated all staff on care services related to identification of change in condition, providing timely treatment as ordered not withholding care, reporting any concerns and notification to physician.

The same education will be provided by the Staff Development Coordinator or designee to agency staff upon first shift worked and all new hires during orientation effective 09/19/24 per directive of the Director of Nursing.

Change in condition identification, notification of physician, validation of timely treatment and follow up will be reviewed in clinical morning meeting Monday through Friday. Any negative findings will be acted upon immediately.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

On 09/19/24 it was established by the Interdisciplinary Team that beginning the week of 9/23/24 through 11/15/24, the following steps will be completed and documented weekly for 8 weeks.

Five interviewable residents will be interviewed weekly by the Director of Social Services or designee to ensure that resident concerns are

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addressed timely, that there are no unresolved concerns, that facility is respecting Resident Rights, that the facility is identifying resident changes in condition, if a resident has had a medical concern the facility has addressed it timely and notified the physician, and have no concerns that have the potential to be considered abuse/neglect.

Five non-interviewable residents will have their medical record reviewed weekly by a clinical manager to identify any concerns related to change in condition, any delay or withholding of care or treatment, or any concerns with Resident Rights, code statuses not being honored will also be reviewed.

Five staff members will be interviewed weekly the Administrator or designee to determine if there are any concerns related to delay in identification in resident Change in Condition, delay or withholding of treatment or concerns regarding physician notification.

Facility Activity Report will be reviewed Monday through Friday in Clinical Morning Meeting to ensure timely identification of Change in Condition, notification of physician, prompt treatment if indicated, appropriate response for a resident that is a full code, timely identification of potential neglect.

The Quality Improvement Committee will review the results of the audits for further recommendation weekly for 8 weeks. Should the committee feel that further auditing is necessary, it will be determined at that time.

Above responsibilities were discussed during

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F 684	Continued From page 47 Ad-hoc QAPI completed on 9/19/24. Alleged Compliance date: 09/20/24 Date of immediate jeopardy removal is 09/20/24 On 09/25/24 the credible allegation of Immediate Jeopardy removal was validated by onsite verification and included: The facility provided documentation to support their corrective action plan. The initial facility audits dated 09/19/24 were reviewed and revealed no issues were noted. Education to licensed nursing, nurse aides and medication aide staff regarding a change in condition was reviewed and sign in sheets were provided. Staff interviews across all departments were able to verbalize they had received education on change in condition, examples of change in condition, and who to notify in the event of a change in condition of a resident. Quality Assurance and Performance Improvement (QAPI) meetings were discussed with the Administrator and meeting notes were reviewed. The facility's compliance date of 09/20/24 for the corrective action plan was validated on 09/26/24.	F 684		