STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375536	A. Building B. Wing	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuscany Village Nursing Center	2333 Tuscany Blvd Oklahoma City, OK 73120

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46216 Based on record review, observation, and interview, the facility failed to ensure timely incontinent care for one (#10) of three sampled residents reviewed for incontinent care. The Resident Census and Condition of Residents report, dated 04/07/23, documented 43 resident were dependent and 31 residents required assistance by one or two staff for toileting. 107 residents resided in the facility. Findings: A Perineal Care policy, dated 02/12/20, read in parts .Staff will provide cleanliness of genitalia to avoid skin breakdown and infection .Staff will perform perineal/incontinent care with each bath and after each incontinent episode . A Resident assessment dated , 12/05/22, documented Resident #10 was always incontinent of bowel and bladder, and was totally dependent on staff for personal care. A Care Plan, last revised 03/25/23, read in parts, .check resident every 2 hours and assist with toileting and as needed . On 04/05/23 at 8:12 a.m., Resident #10 stated that staff entered their room at 7:00 a.m. and Resident #10 infomred them they had not received incontinent care since 9:00 p.m., the previous night. Resident #10 informed the staff member they needed to be changed. On 04/05/23 at 8:26 a.m., CNA #1 entered Resident #10's room ask how they had slept and if he had been changed last night. Resident #10 stated no. On 04/05/23 at 8:28 a.m. CNA #1 and the DON entered the room to provide incontinent care to Resident #10. CNA #1 and the DON positioned Resident #10 to provide incontinent care. The top blankets were removed, CNA#1 was observed to unfasten the brief. The brief was observed to be saturated with brownish, yellow urine. CNA #1 and the DON provided Resident #10 with incontinent care and repositioned Resident #10 in the recliner. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/23 at 12:46 p.m., the DON stated that the policy for timely ADL care was to porvide care immediatly when you discovered a resident needed incontinent care. The DON stated that immobile residents should be checked on every two hours and stated that if a resident was in need of incontinent care it should happen within 15 to 20 minutes. The DON stated that the brief on Residenrt #10 was heavy when incontinent care was provided to Resident #10.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facilities failure to ensure Resident #1 received CPR for one (#10) of two sampled residents for CPR. Resident #1 was admitted to the facility on [DATE] and had diagnoses which included end stage renal disease, hypertension, diabetes mellitus II, iron deficiency and anemia. Resident #1 admitted late in the day and the facility documented TBD as the Resident's code status. No assessments were completed at the time of admission. Resident #1's documentation from the hospital dated [DATE] documented they were a full code status. On [DATE] the fire department arrived to facility at 2:01 p.m. The fire department run report documented upon their arrival at the facility the nurse stated that the patient had been unresponsive for 30 minutes prior to their arrival. Two employees stated to the fire department that the patient had been unresponsive for 30 minutes prior to our arrival. They stated the reason for the delay CPR or calling 911 was due to contacting the patient's physician for medical direction and having to clean the patient due to bowel incontinence. emergency room documentation, documents Due to prolonged downtime and no return of spontaneous circulation, the decision to terminate resuscitation efforts were made. Time of death was noted at 2:52 P.M. on [DATE]. LPN #1, the charge nurse on [DATE], stated CPR was not performed on Resident #1. They stated that they thought Resident #1 had DNR, they could not find it that night. The DON stated, If they don't have an advance directive or a DNR on file they are a full code and it would be expected for staff to perform CPR. On [DATE] at 4:52 p.m., The Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On [DATE] at 5:05 p.m., the Administrator and the DON were notified of the IJ situation. On [DATE] at 9:52 p.m., the facility submitted an acceptable a plan of removal. The plan of removal documented the following: 1) The DON/designee will educate all licensed nurses on when to initiate CPR and what to do if the code status has TBD. Licensed nurses will be shown how to correct the code status order once they confirm whether the resident is a full code or DNR upon admission. They will also be educated by the Director of Nursing or designee by 11:59pm [DATE] that they must print the DNR/Advanced Directive Report from [facility EHR] at the beginning of their shift. Any licensed nurse not educated by end of day on [DATE] will not return to work until they have received the education. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2) DON/Designee will print the DNR/Advance Directive report from [facility EHR] on [DATE] to assure all code status orders are entered correctly. Staff will be educated on where to find the Code Status in [facility EHR] by 11:59pm [DATE]. 3) Mock Code Blue to be initiated for each shift with return demonstration from staff by end of day (11:59PM) 0n [DATE] then randomly weekly for 2 weeks, then q month for 90 days. a. Staff to remain in room and initiate CPR b. Code Blue announced c. C N A or staff will retrieve emergency crash cart and initiate 911 on each shift. The DON/designee will be conducting the code blue. There will be repeat training for any staff that do not achieve successful completion of code blue. On [DATE], staff were interviewed regarding recent training/updates in regards to the CPR policy and protocol. Staff stated they had received in-services/training from the DON/designee and verbalized understanding of the information provided in the in-service pertaining to the plan of removal. On [DATE] at 7:27 p.m., the Administrator RNC #1 and RNC #2 was informed the immediacy was lifted effective [DATE] at 5:30 p.m. The deficiency remained at an isolated level of actual harm. Based on record review and interview, the facility failed to ensure a newly admitted resident's code status was known upon admission. Resident #1's code status upon admission was TBD (to be determined) and the resident was found unresponsive and the charge nurse failed to initiate CPR due to the lack of knowledge of residents code status. The Resident Census and Conditions of Residents report, dated [DATE], documented 107 residents resided in the facility. Findings: AEmergency Standards of Practice policy, revised [DATE], read in parts, .The staff will call 911 .when the resident's condition is life threatening in accordance with his/her Advanced Directives .Qualified staff initiates the appropriate emergency procedure, i.e., oxygen, suction, CPR . A Cardiopulmonary Resuscitation (CPR): Basic Life Support (BLS)/Hands-Only CPR, policy and procedure, revised [DATE], read in parts, .Standard of Practice: CPR (BLS and/or Hands-Only) will be initiated for residents that experience a witnessed or unwitnessed cardiopulmonary arrest while in the community If an individual is found unresponsive by an employee of the community the employee will initiate CPR unless: .it is known that a Do Not Resuscitate order exists for the resident . Resident #1 was admitted to the facility on [DATE] and had diagnoses which included artherosclerotic heart disease of native coronary artery without angina pectoris, diabetes mellitus type 2, chronic kidney disease, stage 3, COPD, and obstructive sleep apnea. The EHR documented Resident #1's code status as TBD. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no documentation in the EHR or admission record the resident had a DNR. Resident #1's documentation from the hospital dated [DATE] documented the Resident had a full code status. A nurse's note, dated [DATE], read in parts, This nurse was called to room due to staff reported unable to obtain O2 sat, unable to feel pulse skin was cool to touch. He was laying on mattress urine output was noted in cath collection system. Notified DON and assistance from another staff member. Notified [DATE] for ambulance for non-responsive resident, upon CPR given EMSA noted area on side of head, unknown to this nurse and not reported, appearance of dried blood noted to face as staff was cleaning resident due to incontinent of BM and .this nurse stated 30 minutes passed and was not clear on the exact time . This note was electronically signed by LPN #1 as a late entry on [DATE] at 9:45 a.m., 27 days after the resident was found unresponsive and CPR was not performed by the facility. A fire department run report, dated [DATE], read in parts, .arrived 14:01:20 [2:01 p.m. and 20 seconds] was this a full arrest yes .attempted defibrillation, attempted ventilation, initiated chest compressions .narrative . upon arrival, the nurse stated the pt had been unresponsive for 30 minutes prior to our arrival. The two employees from the facility who were are the room .stated the reason for delay CPR or calling 911, was due to contacting the physician for medical direction and having to clean the pt due to bowel incontinence .pt was lying supine on the floor unresponsive and pulseless . A hospital emergency room report, dated [DATE], read in parts, .due to prolonged downtime and no return of spontaneous circulation, the decision to terminate resuscitation efforts were made. Time of death was noted at 1452 [2:52 p.m.] . A discharge assessment, dated [DATE], documented Resident #1 had died in the facility. A signed memorandum from the fire department, dated [DATE], read in parts, .On [DATE] at 1357 our fire department responded to a cardiac arrest call at Tuscany Village .upon our arrival we discovered that the patient had been found unresponsive approximately thirty minutes prior to our call. Instead of imitating immediate CPR, the nursing staff focused on cleaning the patient .The delayed initiation of CPR significantly reduced the patient's chance of survival . On [DATE] at 3:45 p.m., LPN #1, the charge nurse on [DATE] stated CPR was not performed on Resident #1. They stated that they thought Resident #1 had DNR, they could not find. On [DATE] at 2:25 p.m. the DON stated, if a resident does have an advance directive or a DNR on file they are a full code and it would be expected for staff to perform CPR. The DON further stated Resident #1 code status was listed as TBD on admission because they were admitted late that evening. The DON further confirmed Resident #1 did not have a DNR or advanced directive and CPR should have been provided. On [DATE] at 2:39 p.m., the admission coordinator stated that Resident #1 came in late on a Friday evening. They stated that if the hospital paperwork says the resident was a full code then on admission the Resident would be a full code and CPR should be performed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 20960 Based on record review and interview, the facility failed to ensure medications were passed as with their scheduled time frames for one (#4) of three sampled residents reviewed for medications. The facility identified 110 residents who resided in the facility. Findings: A facility policy Liberalized and Standardized Medication Administration Schedules, effective March 2023, read in parts, .Liberalized schedules .are considered timely as long as they are administrated within two (2) hours . The facility form titled, Tuscany Village medication Times, read in parts .QD= 0800 [8:00 a.m.] .BID= 0800-200 [8:00 a.m. and 8:00 p.m.] Resident #4 had diagnoses which included hypertension, insomnia, atrial fibrillation, and hypothyroidism. Resident #4 had the following medications order: Eliquis 5 mg one tablet by mouth two times a day at 8:00 a.m. and 5:00 p.m. for atrial fibrillation; and Digoxin 125 mcg one tablet by mouth one time a day at 9:00 a.m. for atrial fibrillation; A review of the Medaid Mar for March 2023 documented Resident #4 was administered the following medications late on 03/16/23: Eliquis 5 mg tablet due at 8:00 a.m. was provided at 11:30 a.m. Digoxin 125 mcg tablet due at 9:00 a.m. was provided at 11:30 a.m. On 04/10/23 at 10:33 a.m., the DON stated the medications were not administered correctly and on time resulting in an error.