STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455823	A. Building B. Wing	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Healthcare and Rehabilitation Center	5550 Harvest Hill Rd Dallas, TX 75230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44006 Based on interviews and record review, the facility failed to provide basic life support, including CPR (Cardiopulmonary Resuscitation), to a resident who required such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 5 residents (Resident #1) reviewed for CPR. Nursing staff failed to provide CPR for Resident #1, who had a full code status and was found unresponsive with no pulse. CPR was not provided for approximately six minutes until EMS arrived and started CPR. Resident #1 expired at the facility on [DATE]. This failure placed residents who had a full code status at risk of not receiving necessary life-saving measures, which could result in death. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 3:46 PM. While the IJ was removed on [DATE] at 3:55 PM, the facility remained out of compliance at a scope of isolated and with actual harm that is not immediate, due to the facility's need to evaluate the effectiveness of the corrective systems . Findings Include: A record review of Resident #1's electronic face sheet, dated [DATE], revealed Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included frontal lobe and executive function deficit following cerebral infraction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), gastroparesis (a disorder that slows or stops the movement of food from your stomach to your small intestine), type 2 diabetes mellitus (a group of diseases that affect how the body uses blood sugar) with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), bipolar disorder, anxiety disorder, chronic pain syndrome, psychoactive substance abuse and essential primary hypertension. The face sheet revealed Resident #1's code status as Full Code (full code allows for all interventions needed to restore breathing or heart functioning, including chest compressions, CPR , a defibrillator, and a breathing tube.). (continued on next page)

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

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident #1's Comprehensive MDS, dated [DATE], revealed she had a BIMS of 12, which indicated her cognition was moderately impaired. A record review of Resident #1's Care Plan, dated [DATE], revealed Resident #1 had shortness of breath pain with the following interventions: Assist resident/family/ caregiver in learning signs of respiratory compromise. Refer significant other/caregiver to participate in basic life support class for CPR, as appropriate. Maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as needed to clear secretions. Further review of the Care Plan revealed Resident #1 was a Full Code, and the interventions included the following: Request for CPR to be initiated will be followed. Notify the charge nurse immediately if the resident is not breathing or does not have a heartbeat. CNA consult with nursing staff on changes in health. A record review of Resident #1's Progress Notes, dated [DATE], revealed LVN A documented 1:25 Resident was in her usual state of health feeding herself in the dinning area, seen 5 minutes earlier. CNA called this nurse attention to notify her that Resident eating in dinning place was not responsive to calls and was moved to her room by the help of the unit manager. Activity Director was met along the way with the same message. This nurse went to the resident room noted resident in bed, with shallow breathing (shorter inhaling and exhaling than normal breathing but with an equal cadence) , lethargic, thready/faint pulse of 60, Rr (respiration rate)12cpm (cycles per minutes), temp. (temperature) 97.2, BS (blood sugar) 373, O2 (oxygen) sat . (saturation) 66%, BP unrecordable, O2 was applied at 10 LPM (liters per minute) O2 level rise to 86%, Code blue was called along with CPR initiation Resident is full code. 13:30 Resident still unresponsive, unable to locate pulse, 13:32 911 called 13:40 EMS took over CPR. 13:45 [family member] called waiting on call back. 14:10 911 call off CPR, and resident pronounced dead. 14:25 [family member] called back and updated on resident state of condition. Dallas medical examiner office called spoke with [family members]. Case #,d+[DATE] was given. Family member in attendance, unit manager and facility social around for needed support. Family given information and case number for further arrangement. Awaiting remove of Body. A record review of EMS incident report, dated [DATE], revealed Narrative: [Paramedic] arrived on scene to find an unconscious 40 y/o female at a rehabilitation center. Staff called in a unwitnessed cardiac arrest and pt (patient) was not touched for 6 minutes prior to [EMS] arrival. [EMS] began CPR, BVM (bag-valve-mask) with oxygen and attached their AED to the pt. Upon [EMS] arrival, pt was transferred from the AED to the Lifepack (a multi-parameter device that combines semi-automated and manual defibrillation with capnography, external pacing, 12-lead electrocardiography and other monitoring functions) Pt rhythm was in asystole (a type of cardiac arrest, which is when your heart stops beating entirely and have no pulse). [Paramedic] took over CPR and asystole protocols were followed. IO (Intraosseous lines) was established. Capno (carbon dioxide) was applied but due to poor reading pt airway was suctioned and king tube was placed. BVM with oxygen was continued. First epi (epinephrine injection) was pushed. 782 arrived on scene and got on the phone with biotel. CPR protocols were followed. CPR was discontinued by Biotel at 14:08 per [physician]. Further review of the EMS incident report revealed Resident #1's Initial rhythm: Asystole and CPR Prior to EMS: No. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the medical examiner report, dated [DATE] at 4:46 PM, revealed Investigation Narrative: On [DATE] @ 1434 hours, this office was notified of the apparent natural death of a 40 (age)/NA (Native American)/F (female), [Resident #1]. Per [facility staff RN B], The deceased (decd) had a hx (history) of CVA (stroke), ESRD (end-stage renal disease), HTN (hypertension), DM (diabetes), and gastroparesis and was admitted on [DATE]. The decd was witnessed to go unresponsive by staff who called 911. [EMS] responded and pronounced the death at 1415 hours. No trauma or history of Trauma was reported. [Facility Physician] will sign death certificate with the above diagnoses as the cause of death. MDI (Medicolegal Death Investigation) confirmed the above information with [Resident #1's family member]. He denied hx of trauma and EtOH (ethyl alcohol), tobacco, and illicit drug use. In an interview on [DATE] at 4:30 PM, Resident #1's family member, they stated they were told by RN B, who identified himself as the Unit Manager, that Resident #1 had become unresponsive, and the facility did not perform CPR. Resident #1's family member stated they told RN B Resident #1 had a full code status and asked why the facility did not perform CPR. Resident #1's family member stated RN B mumbled something low that they could not understand because RN B had a heavy accent. Resident #1's family member stated they did not ask RN B to repeat what he stated because at that point they were just really upset the facility had not performed CPR. In an initial interview on [DATE] at 12:05 PM, LVN A stated on [DATE] she was the nurse for Resident #1. LVN A stated CNA C called her and RN B to the dining area because Resident #1 was unresponsive. She stated she was just in the dining room about 5 minutes before and Resident #1 had asked her for more tea, and she refilled her tea. LVN A stated Resident #1 was talking and acting like her normal self, so she was shocked when Resident #1 became unresponsive. LVN A stated when Resident #1 became unresponsive, and she was unable to get a pulse via the wrist but there was a slight pulse on the neck. She stated she called a code blue, which meant the resident was in distress and needed emergency help. LVN A stated they moved Resident #1 to her room. She stated Resident #1 was gasping for air and they could not find a pulse, so they initiated CPR, since Resident #1 was full code. LVN A stated she wasn't sure who performed CPR on Resident #1, but it was done. When LVN A was asked why she documented CPR was initiated, if she could not identify who performed CPR, she stated she believed it was RN B. In an initial interview on [DATE] at 12:22 PM, RN B stated he was the Unit Manager and was called to the dining room by CNA C because Resident #1 was not responding. He stated when he entered the dining room Resident #1 was slumped over in her wheelchair and was not responding. RN B stated he found a slight pulse via the neck, so he and CNA C moved Resident #1 to her room. He stated once they got her on the bed, he was assessing vitals and he could not find a pulse on the wrist or neck. RN B stated the Activity Director (AD), ADON, and DON had come to Resident #1's room, while he was getting vitals. He stated they initiated CPR. When RN B was asked who performed CPR, he stated he was in and out of the room getting things, but he believed it was the DON . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an initial interview with the DON on [DATE] at 1:20 PM, she stated CNA C found Resident #1 unresponsive in the dining room. The DON stated CNA C called LVN A and RN B to the dining room. She stated it was reported that it was a sudden change in condition because the resident had been observed 5 minutes earlier by LVN A and she was her normal self. The DON stated she, the ADON, the AD, and RN B were in Resident #1's room. She stated when she entered Resident #1's room she heard her making shallow breaths and she was connected to the pulse oximeter, and it read 60. The DON stated she did not perform CPR because Resident #1 had a pulse, via the pulse oximeter. She stated she was stimulating Resident #1's chest by rubbing it and her pulse increased to 67. The DON stated EMS arrived just a couple minutes after she arrived at Resident #1's room. She stated EMS took over and immediately started CPR. The DON stated she did not know why EMS immediately started CPR, since Resident #1 had a pulse. She stated it was their policy not to perform CPR, if resident had a pulse. The DON stated she did see LVN A's documentation in Resident #1's medical record, and it was inaccurate. She stated she did know why LVN A documented CPR was done, when it was not done. She stated this was false documentation and was a risk to the resident because it was an inaccurate depiction of the resident's care. In a follow up interview on [DATE] at 3:28 PM, RN B stated he did not provide correct information in his initial interview because he was reading from LVN A's documentation in Resident #1's medical record. He stated no one performed CPR because Resident #1 had a pulse via the pulse oximeter. He stated on [DATE] CNA C called him to the dining room because Resident #1 was unresponsive. He stated he checked Resident #1's wrist and could not get a pulse, so she tried her neck and there was a faint pulse. RN B stated he and CNA C took Resident #1 to her room. He said the AD was in the dining room and he told him to go get LVN A. RN B stated he and CNA C transferred Resident #1 to her bed and he started to get vitals. He stated Resident #1 was not responding. RN B stated the AD and LVN A entered Resident #1's room. He stated he told LVN A to call code blue and told the AD to call 911. RN B stated he continued to get vitals. He stated he was not getting a pulse via the wrist or neck, but once the pulse oximeter was placed on Resident #1's finger it read at 60. RN B stated he did not remember where he got the pulse oximeter from or the timeframe between not getting a pulse and when he applied the pulse oximeter to Resident #1's finger. When RN B was asked, why didn't he just start CPR prior to applying the pulse oximeter, when he could not get a pulse on Resident #1's wrist or neck, he said because he left the room to get the crash cart. He stated he doesn't remember if he got the pulse oximeter off the crash cart. RN B stated he was supposed to perform CPR if the resident was unresponsive and there was no pulse . In a follow up interview on [DATE] at 10:49 AM, the DON stated she did not know why the EMS incident report would indicate there was no pulse when they arrived. She stated maybe that was their interpretation of things or maybe when she stepped away and they took over Resident #1 loss her pulse. The DON stated she did see that LVN A documented in Resident #1's medical records that she was unresponsive and had no pulse at some point. She stated she believed this was inaccurately documented, but the entire time she was around Resident #1 she had a pulse, via the pulse oximeter. When the DON was asked if she ever checked Resident #1's neck for a pulse, she stated she did check Resident #1's neck and there was a pulse. The DON stated she was never informed by LVN A or RN B that at some point during the situation, they were unable to locate a pulse. She stated if Resident #1 was unresponsive and LVN A or RN B could not find a pulse, then they should have immediately started CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a follow up interview on [DATE] at 1:16 PM, LVN A stated her documentation was inaccurate. She stated CPR was never done on Resident #1. LVN A stated she was in and out of Resident #1's room bringing equipment for the code blue and at one point, she saw the DON touching Resident #1's chest, so she assumed she was doing CPR and documented it. LVN A stated she never performed CPR on Resident #1 because she always had a pulse when she took her vitals. LVN A was asked why she documented in Resident #1's medical record at 13:30 Resident still unresponsive, unable to locate pulse, if she always had a pulse and why in her initial interview, she said they were unable to locate a pulse. LVN A stated when RN B was getting vitals in Resident #1's room, he asked her to go get the glucometer. She stated when she returned to the room to give RN B the glucometer, she heard him saying he could not find a pulse, so she documented it. LVN A stated she did not see RN B start CPR when she heard him say he could not find a pulse. She stated she did not start CPR when she heard RN B say he could not find a pulse because he was the unit manager and had taken over the situation. In an interview on [DATE] at 10:01 AM, CNA C stated she was in the dining room feeding a resident and LVN A was in there as well. She stated Resident #1 asked for more tea and LVN A refilled the tea. CNA C stated Resident #1 was acting normal . She stated about 5 minutes later she saw Resident #1 slumped over in her wheelchair. CNA C stated she went to check on Resident #1. She said she called her name and tapped her shoulder, but she was not really responding. CNA C stated she was just mumbling in a low voice, and she could not understand what she was saying. She stated normally Resident #1 talked and was understandable. CNA C stated the resident would not lift her head and continued to stay slumped over in her wheelchair. She stated she ran into the hall to get help. CNA C stated she went down the hall looking for LVN A but found RN B. She stated RN B said he wanted to take her to her room, so she helped take the resident to the room and transferred her to the bed. CNA C stated RN B was calling Resident #1's name but she was not responding. She stated the AD and LVN A came into Resident #1's room, so she left the room. In an interview on [DATE] at 11:58 AM, the AD stated he was in the dining room making pancakes and he heard CNA C calling Resident #1's name. He stated when he looked in that direction, he saw Resident #1 was slumped over in the wheelchair. The AD stated he had just talked to her a few minutes earlier when he gave her pancakes. He stated Resident #1 was fine. The AD stated CNA C told him to get LVN A. He stated he located LVN A in a resident's room and she was doing something to a g-tube. The AD stated LVN A finished connecting the g-tube and then they started towards the dining room. He stated he saw RN B and CNA C in the hall taking Resident #1 to her room. The AD stated he and LVN A followed. He stated once they entered the room CNA C left the room. He stated he saw RN B and LVN A trying to get vitals and they were checking Resident #1's wrist and neck. The AD stated he heard them saying they couldn't find Resident #1's pulse. He stated they told him to call 911 and get Resident #1's face sheet. The AD stated he left the room. He stated as he was leaving the room, he saw the DON and ADON heading towards Resident #1's room. The AD stated when he returned to Resident #1's room, he saw RN B, the ADON and the DON around the resident. He stated Resident #1 was connected to the pulse oximeter. The AD stated he didn't know when they connected Resident #1 to the machine because he left the room. He stated he was standing in Resident #1's room on the phone with 911 and answering their questions. The AD stated EMS arrived about ,d+[DATE] minutes after he called them. He stated he was in the room when they arrived. The AD stated as soon as they entered, RN B, the ADON and the DON immediately moved out of the way, and the EMS worker stepped in. The AD stated the first thing EMS did was check Resident #1's neck, said there was no pulse, and started chest compressions. He stated they got this machine and suctioned her neck. The AD stated after they suctioned her neck, EMS put a blue device over her mouth and was squeezing it. He stated they continued to do CPR for about 15 minutes. The AD stated EMS was not able to bring Resident #1 back. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 2:55 PM, the facility's Marketing RP stated she was a RN, so the facility required her to be in-serviced on CPR. She stated she was happy to see staff were being in-serviced on CPR because she witnessed the incident that happened to Resident #1. She stated she was in the hallway and saw a nurse (doesn't know their name) moving the AED in a fast pace. The Marketing RP stated she followed the nurse to Resident #1's room. She stated when she arrived at the room, she observed Resident #1 laying on bed gasping for air and her pupils were dilated. The Marketing RP stated the gasping sound Resident #1 made seemed as if her airway was clogged, and she was not breathing properly. She stated the DON was rubbing the resident's chest for stimulation but was not performing CPR. The Marketing RP stated she was wondering why they were not doing CPR because it was clear to her Resident #1 was not breathing and was dying. The Marketing RP stated she did not say anything because the DON was right there, and she was following chain of command. She stated the AD was in the room on the phone with 911 and she heard him say to the DON they were saying to do CPR. The Marketing RP stated the DON said to the AD, but she has a pulse. She stated she did not see the DON checking Resident #1's pulse. She stated they were using the pulse oximeter on Resident #1, but based on her training that was not reliable, especially in this situation. She stated the pulse oximeter measures oxygen in the blood but Resident #1 was not breathing well because she could hear her gasping for air, so they should have been getting the pulse from the carotid artery (neck). The Marketing RP stated while she was in the room, she did not observe anyone checking for a pulse via Resident #1's neck. She stated she did not know if they checked prior to her entering the room. She stated she was in the room approximately 3 to 4 minutes before EMS arrived. She stated once EMS arrived the DON stepped back, and they took over. The Marketing RP stated EMS checked the resident's pulse via the neck and she heard EMS say she had no pulse, so they immediately started with chest compressions. She stated EMS suctioned Resident #1 and continued with CPR. The Marketing RP stated EMS worked on Resident #1 for 28 minutes and then pronounced Resident #1 dead. A record review of the facility's policy titled Cardiopulmonary Resuscitation, dated [DATE], revealed Procedure: 1. Assess for unresponsiveness. Tap the resident's shoulder and ask the resident if he/she is alright. 2. When the resident is unresponsive, immediately call for emergency help and notify staff of Code Blue. Call emergency assistance. Ensure the first responder called EMS and returns to the scene with any AED (defibrillator). If you are alone and cannot alert anyone to call EMS, YOU MUST call EMS prior to beginning CPR and obtain the AED. 3. After EMS has been called, implement the CPR protocol as outlined below (chest compressions-Airway-Breathing (C-A-B) . 5. Check the unresponsive resident for a pulse for no longer than 10 seconds c. Adult- check for a pulse at carotid artery. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 3:50 PM. The Administrator was notified. The Administrator was provided with the IJ Template on [DATE] at 3:56 PM. The following Plan of Removal (POR) submitted by the facility was accepted on [DATE] at 12:15 PM: Interventions: On [DATE] All resident records were audited by the DON, ADON, and/or regional nursing staff to ensure that a code status was current and that the care plan reflected that order. On [DATE], Regional Nurse consultant immediately in-serviced, DON and ADON on CPR initiation, notification of physician, DNR, and documentation. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] all licensed nurses were in serviced by the DON, ADON, and/or regional nursing staff regarding: All staff not present will not resume duties until in-serviced before start of shift. o Initiating CPR in the absence of a DNR . Either: A Texas Out of Hospital DNR or Physician's order for DNR If a resident is found, unconscious, absent of breathing and heart rate, with an absence of a DNR or physicians order for DNR, CPR will be immediately initiated at the same scene resident is found. o How to obtain the residents code status in PCC (resident record, EMAR , POC) o Nurses not stopping CPR unless: Receive a physician order to stop CPR, by phone or in person. EMS takes over the CMS/Code o Do not stop CPR unless the above criteria are met. o Notifying the physician and family of any resident change in condition. On [DATE] all nursing staff were in-serviced by the DON, ADON, and/or regional nursing staff on how to locate a resident's code status in PCC (resident record, EMAR, POC). All staff not present will not resume duties until in-serviced before start of shift. On [DATE] at 4:25 PM the Medical Director was notified regarding the plan the facility initiated an ADHOC plan for this occurrence. Monitoring: At least 5 times per week, orders will be reviewed by the DON and/or ADON and ensure that advanced directive orders are entered correctly. The DON and/or ADON will interview at least 10 licensed nurses per week and questions will include: o When should you start CPR? o When can you stop CPR? o Where to locate a resident's code status? o How to initiate a resident/representative request for DNR (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Healthcare and Rehabilitation Center	5550 Harvest Hill Rd Dallas, TX 75230

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44006 Based on interview and record review the facility failed to ensure medical records were maintained in accordance with accepted professional standards and practices on each resident that were accurately documented for 1 of 5 residents (Resident #1) reviewed for accuracy of medical records. The facility failed to ensure Resident #'1's electronic medical record contained accurate documentation in that LVN A documented Resident #1 received CPR after she went unresponsive. This failure could place residents at risk for errors in care and treatment. Findings include: A record review of Resident #1's electronic face sheet, dated [DATE], revealed Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included frontal lobe and executive function deficit following cerebral infraction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), gastroparesis (a disorder that slows or stops the movement of food from your stomach to your small intestine), type 2 diabetes mellitus (a group of diseases that affect how the body uses blood sugar) with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), bipolar disorder, anxiety disorder, chronic pain syndrome, psychoactive substance abuse and essential primary hypertension. The face sheet revealed Resident #1's code status as Full Code (full code allows for all interventions needed to restore breathing or heart functioning, including chest compressions, CPR , a defibrillator, and a breathing tube.). A record review of Resident #1's Comprehensive MDS, dated [DATE], revealed she had a BIMS of 12, which indicated her cognition was moderately impaired. A record review of Resident #1's Care Plan, dated [DATE], revealed Resident #1 had shortness of breath pain with the following interventions: Assist resident/family/ caregiver in learning signs of respiratory compromise. Refer significant other/caregiver to participate in basic life support class for CPR, as appropriate. Maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as needed to clear secretions. Further review of the Care Plan revealed Resident #1 was a Full Code, and the interventions included the following: Request for CPR to be initiated will be followed. Notify the charge nurse immediately if the resident is not breathing or does not have a heartbeat. CNA consult with nursing staff on changes in health. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #1's Progress Notes, dated [DATE], revealed LVN A documented 1:25 Resident was in her usual state of health feeding herself in the dinning area, seen 5 minutes earlier. CNA called this nurse attention to notify her that Resident eating in dinning place was not responsive to calls and was moved to her room by the help of the unit manager. Activity Director was met along the way with the same message. This nurse went to the resident room noted resident in bed, with shallow breathing (shorter inhaling and exhaling than normal breathing but with an equal cadence) , lethargic, thready/faint pulse of 60, Rr (respiration rate)12cpm (cycles per minutes), temp . (temperature) 97.2, BS (blood sugar) 373, O2 (oxygen) sat . (saturation) 66%, BP unrecordable, O2 was applied at 10LPM (liters per minute) O2 level rise to 86%, Code blue was called along with CPR initiation Resident is full code. 13:30 Resident still unresponsive, unable to locate pulse, 13:32 911 called 13:40 EMS took over CPR. 13:45 [family member] called waiting on call back. 14:10 911 call off CPR, and resident pronounced dead. 14:25 [family member] called back and updated on resident state of condition. Dallas medical examiner office called spoke with [family members]. Case #,d+[DATE] was given. Family member in attendance, unit manager and facility social around for needed support. Family given information and case number for further arrangement. Awaiting remove of Body. A record review of EMS incident report, dated [DATE], revealed Narrative: [Paramedic] arrived on scene to find an unconscious 40 y/o female at a rehabilitation center. Staff called in an unwitnessed cardiac arrest and pt (patient) was not touched for 6 minutes prior to [EMS] arrival. [EMS] began CPR, BVM (bag-valve-mask) with oxygen and attached their AED to the pt. Upon [EMS] arrival, pt was transferred from the AED to the Lifepack (a multi-parameter device that combines semi-automated and manual defibrillation with capnography, external pacing, 12-lead electrocardiography and other monitoring functions) Pt rhythm was in asystole (a type of cardiac arrest, which is when your heart stops beating entirely and have no pulse). [Paramedic] took over CPR and asystole protocols were followed. IO (Intraosseous lines) was established. Capno (carbon dioxide) was applied but due to poor reading pt airway was suctioned and king tube was placed. BVM with oxygen was continued. First epi (epinephrine injection) was pushed. 782 arrived on scene and got on the phone with biotel. CPR protocols were followed. CPR was discontinued by Biotel at 14:08 per [physician]. Further review of the EMS incident report revealed Resident #1's Initial rhythm: Asystole and CPR Prior to EMS: No. In an interview on [DATE] at 4:30 PM, Resident #1's family member , they stated they were told by RN B, who identified himself as the Unit Manager, that Resident #1 had become unresponsive, and the facility did not perform CPR. Resident #1's family member stated they told RN B Resident #1 had a full code status and asked why the facility did not perform CPR. Resident #1's family member stated RN B mumbled something low that they could not understand because RN B had a heavy accent. Resident #1's family member stated they did not ask RN B to repeat what he stated because at that point they were just really upset that the facility had not performed CPR . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an initial interview on [DATE] at 12:05 PM, LVN A stated on [DATE] she was the nurse for Resident #1. LVN A stated CNA C called her and RN B to the dining area because Resident #1 was unresponsive. She stated she was just in the dining room about 5 minutes before and Resident #1 had asked her for more tea, and she refilled her tea. LVN A stated Resident #1 was talking and acting like her normal self, so she was shocked when Resident #1 became unresponsive. LVN A stated when Resident #1 became unresponsive, and she was unable to get a pulse via the wrist but there was a slight pulse on the neck. She stated she called a code blue, which meant the resident was in distress and needed emergency help. LVN A stated they moved Resident #1 to her room. She stated Resident #1 was gasping for air and they could not find a pulse, so they initiated CPR, since Resident #1 was full code. LVN A stated she wasn't sure who performed CPR on Resident #1, but it was done. When LVN A was asked why she documented CPR was initiated, if she could not identify who performed CPR, she stated she believed it was RN B. In a follow up interview on [DATE] at 1:16 PM, LVN A stated her documentation was inaccurate. She stated CPR was never done on Resident #1. LVN A stated she was in and out of Resident #1's room bringing equipment for the code blue and at one point, she saw the DON touching Resident #1's chest, so she assumed she was doing CPR and documented it . In an interview with the DON on [DATE] at 1:20 PM, she stated CNA C found Resident #1 unresponsive in the dining room. The DON stated CNA C called LVN A and RN B to the dining room. She stated it was reported that it was a sudden change in condition because resident had been observed 5 minutes earlier by LVN A and she was her normal self. The DON stated she, the ADON, the AD, and RN B were in Resident #1's room. She stated when she entered Resident #1's room she heard her making shallow breaths and she was connected to the pulse oximeter, and it read 60. The DON stated she did not perform CPR because Resident #1 had a pulse, via the pulse oximeter. She stated she was stimulating Resident #1's chest by rubbing it and her pulse increased to 67. The DON stated EMS arrived just a couple minutes after she arrived at Resident #1's room. She stated EMS took over and immediately started CPR. The DON stated she did see LVN A's documentation in Resident #1's medical record, and it was inaccurate. She stated she did not know why LVN A documented CPR was done, when it was not done. She stated this was false documentation and was a risk to the resident because it was an inaccurate depiction of the resident's care. A record review of the facility's, undated, policy titled Documentation revealed The facility will maintain complete and accurate documentation on each resident on all appropriate clinical record sheets.