STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505202	A. Building B. Wing	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - 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** 44295 Based on interview and record review the facility failed to have systems in place that ensured basic life support was initiated, including Cardio-Pulmonary Resuscitation (CPR- an emergency procedure consisting of chest compressions combined with giving breaths of air) when one of one residents reviewed for emergency situations (Resident 1) was found unresponsive and required immediate staff action. The failure of facility staff to initiate basic life support, including CPR potentially contributed to the residents unsuccessful response to CPR when initiated by 911 emergency responders and increased the likelihood/risk of serious imminent harm for all residents who choose to have CPR initiated in an emergency. On [DATE] at 5:13 PM, the facility was notified of an immediate jeopardy in F678. The facility removed the immediacy on [DATE] by re-educating the facility staff on policies and procedures for CPR, which included mock code drills, and an audit of staff CPR cards, an audit of deaths in the past 30 days, and an audit of all resident Portable Orders for Life-Sustaining Treatment (POLST- a form that directed medical staff what to do if the resident had a medical emergency) forms and identified CPR certified staff on the daily schedule which ensured an effective system was in place to provide needed services when residents require life-saving measures. Findings included . Review of a [DATE] facility Cardiopulmonary Resuscitation (CPR) policy showed if a resident experienced cardiac arrest (a medical emergency when the heart stops beating) the staff would provide basic life support, including CPR, prior to the arrival of emergency medics. CPR certified staff would be available at all times and staff would maintain current CPR certification. Resident 1 According to the [DATE] Quarterly Minimum Data Set (an assessment tool) Resident 1 admitted to the facility on [DATE] and had medically complex conditions including; diabetes, dementia, and chronic kidney disease. Resident 1 had a life expectancy of six months or more. Review of Resident 1's medical record showed a [DATE] POLST form signed by Resident 1 and the Physician. The POLST form showed Resident 1 chose CPR and full treatment if they were found without a pulse or breathing. (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	Review of Resident 1's physician's orders (PO) showed a [DATE] PO for Full Code (if a person's heart stopped beating or they stopped breathing, all resuscitation procedures will be provided to keep them alive). Review of a [DATE] Advanced Directive (a legal document that specifies what actions should be taken for their health when a resident was not able to make that decision) care plan (CP) showed Resident 1 had a POLST completed and was a full code. The CP showed staff would understand and follow the healthcare directive. Review of Nursing Progress Notes (NPN) showed on [DATE] at 11:30 PM Staff C (Licensed Practical Nurse-LPN) documented that Staff E (Hospitality Aide) and Staff F (Certified Nursing Assistant - CNA) went to Resident 1's room at 9:23 PM and found the resident non-responsive. The NPN showed Staff C checked Resident 1, confirmed they were non-responsive and called 911 for emergency assistance. A supplemental note on [DATE] at 11:40 PM showed that paramedics arrived, and Resident 1 passed away at 10:00 PM. In an interview on [DATE] at 10:58 AM Police Officer 1 stated they (Police Officer 1 and 2) received a call at 9:30 PM for an unresponsive individual and arrived at the facility at 9:33 PM. Upon their arrival to the building they were delayed entering the building, due to the front door being locked and no staff available in the facility lobby to let them in the building. Once Officers arrived to Resident 1's room they observed 5 staff members (Staff C, Staff D, Staff G, Staff F, and Staff J (CNA) , Resident 1 on the floor, and no staff performing any CPR or life-saving measures. Police Officer 2, a certified Emergency Medical Technician (EMT specially trained and certified to administer basic emergency services), asked the facility staff about a DNR (Do Not Resuscitate) order for Resident 1 and was told the Resident did not have one. Police Officer 2 questioned why CPR was not started if Resident 1 was a full code and proceeded to check Resident 1 who was still warm to the touch, and began chest compressions at 9:36 PM. Police Officer 1 stated all but 1 staff member left the room and when they asked for help by staff, a staff member directed another staff member to help with compressions and that staff member left the room. Police Officer 2 requested an oxygen mask. The facility staff attempted to give it to Police Officer 2 who was performing chest compressions instead of putting the oxygen mask on the Resident themselves. When EMT's arrived they took over resuscitation efforts that were unsuccessful and Resident 1 passed away at 9:57 PM. In an interview on [DATE] at 4:27 PM Staff C stated they asked Staff E and Staff F to check on Resident 1 and obtain vital signs. On [DATE] at 9:23 PM Staff E and Staff F found Resident 1 to be unresponsive and notified Staff C. Staff C stated they went to Resident 1's room and checked for a pulse, no pulse was detected and they directed Staff E and Staff F to get the crash cart and inform the other nurses on the floor that help was needed with Resident 1. Staff C stated they called 911 from the nurses station and Staff D (Registered Nurse-RN) and Staff G (LPN) went to Resident 1's room with the crash cart. Staff C stated they did not initiate CPR for Resident 1 because they were on the phone with 911. Staff C stated they were preparing the transfer paperwork (pertinent resident medical information that it sent to the hospital with the resident) and did not see if Staff D or Staff G initiated CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a [DATE] facility provided Detailed History for fire incident from the local police and fire dispatch department showed at 9:28 PM police and fire were dispatched to the facility for an unresponsive resident. Police arrived on scene first at 9:33 PM. This revealed that facility staff called 911 at 9:28 PM, five minutes after Resident 1 was found not breathing or with a heart rate. Police arrived on scene at 9:33 PM and per Officer 1's statement, Officer 2 initiated CPR at 9:36 PM, leaving an additional 8 minutes the staff failed to render emergency care to Resident 1, for a total of 13 minutes. In an interview on [DATE] at 9:37 AM Staff D stated at approximately 9:40 PM on [DATE] Staff F informed them that Staff C needed urgent help with Resident 1 because the resident was not breathing. Staff D stated they locked their medication cart and went to Resident 1's room where they met Staff C in the hallway pushing the crash cart. Staff D told Staff C finish the transfer paperwork and they [Staff D, Staff G, and Staff F) would initiate CPR. Staff D had staff clear the room of equipment and placed Resident 1 on the floor. Staff D stated they were about to kneel down and start compressions when officers arrived on scene. Staff D stated they did not start compressions on Resident 1. Attempts were made to contact other staff, present at the time police arrived and that were not involved in CPR. None of these staff responded to these attempts to obtain first hand information about what transpired the care of Resident 1. In an interview on [DATE] at 2:00 PM Staff B (Director of Nursing) stated there was a miscommunication between the aides (Staff F and Staff E) and Staff C. The aides informed Staff C that Resident 1 was unresponsive, not that they were not breathing or had no heart rate. When asked why Staff F and Staff E who found Resident 1 unresponsive didn't start CPR, Staff B was not sure. When asked which staff member initiated CPR, Staff B stated Staff C and Staff D did initiate CPR. Staff B was asked why Staff C & Staff D's statements and interviews showed they did not initiate CPR, Staff B replied that Staff C called 911 first to get Resident 1 help faster. Staff B acknowledged there was a delay in initiating CPR for Resident 1 and the staff who found the Resident unresponsive should have initiated CPR immediately and had another staff member call 911. REFERENCE: WAC [DATE](1)