| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675423 | A. Building<br>B. Wing | 03/21/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ashford Gardens | 7210 Northline Dr<br>Houston, TX 77076 |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870<br><br>Based on interview and record review, the facility failed to ensure that 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 for one (CR#1) of six residents reviewed for CPR.<br><br>-The facility failed to initiate and conduct CPR immediately after finding CR#1 unresponsive.<br><br>-The facility failed to immediately contact 911 for EMS services; EMS was not contacted until approximately 31 minutes after the resident was found unresponsive.<br><br>-The facility to perform CPR appropriately as LVN B instructed a CNA to clean CR#1 of a bowel movement.<br><br>-The facility failed to follow CPR protocol resulting in delayed treatment, improper documentation, and delayed notification to the family and physician.<br><br>An Immediate Jeopardy (IJ) situation was identified on [DATE] at 2:52 p.m. While the IJ was removed on [DATE] at 2:07 p.m., the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>This failure could affect Full Code Residents who could need CPR by placing them at risk of death.<br><br>Findings Included:<br><br>CR#1<br><br>Record review of CR#1's face sheet revealed CR#1 was a [AGE] year-old female resident admitted to the facility on [DATE]. CR#1 was discharged at the time of death on [DATE] at 8:06 am. CR#1's diagnoses included cerebrovascular disease (stroke), dementia (memory loss), Diabetes Type ll (resists insulin), conversion disorder with seizures or convulsions (non-epileptic seizures), chronic kidney disease (kidney failure), and contracture of left and right knee (knee unable to fully extend).<br><br>(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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of CR#1 Comprehensive MDS assessment dated [DATE] revealed CR#1 had a BIMS score of 11 indicating moderately impaired cognition. CR# required extensive assistance by one-person physical assist for all ADLs. CR#1 was incontinent to bowel and bladder. CR#1 had a g-tube.<br><br>Record review of CR#1s Care plan dated ,d+[DATE] through present revealed CR#1 was full code status.<br><br>Record review of Progress Note dated [DATE] revealed LVN B entered note on [DATE] at 8:55 a.m. that read, went in<br><br>to speak to patient during rounds, although patient is nonverbal. Left out of room when informed by another CNA another patient (roommate) needed my assistance in the dining room. Note effective date and time of the occurrence was [DATE] at 6:30 a.m.<br><br>Record review of Progress Notes dated [DATE] revealed LVN B entered note on [DATE] at 9:07 a.m. that read, When going to do blood sugar and give meds, I spoke to patient and told her I need to do her blood sugar, as normal sometimes she will respond, I took her hand to do the blood sugar and after I stuck her and got the blood, the reading was 59 and a BP of ,d+[DATE] with a pulse of 101, I noticed she did not respond as usual. I then shook patient and called out her name again with no response. Then 911 was immediately called. I then pulled back the covers and still got response, I then check for a pulse and got no pulse, then CPR was started. The med aide was called from the hallway for help, I instructed her to get the other nurse while continuing CPR. Upon the other nurse coming in, he went to get the crash cart, when he returned, the patient was placed on the floor on a backboard and CPR was continued until EMS arrived, case was then transferred to EMS. Effective date and time of occurrence was [DATE] at 8:55 a.m.<br><br>Record review of SBAR Communication Form completed by LVN B on [DATE] at 9:22 a.m. revealed CR#1's symptoms of low vitals began on [DATE]. Things that make the symptom better are CPR. Vitals were documented as: Pulse- 101; blood sugar- 59; BP- ,d+[DATE]. CR#1 had decreased level of consciousness, decreased mobility, no changes in respiratory evaluation, and resting pulse greater than 100. Observation and evaluation were summarized as patient not a normal baseline, vital signs taken (BP ,d+[DATE], P-101, BS-59), patient not responding, CPR started. Physician and family notified at 9:00 am on [DATE].<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on [DATE] at 11:25 a.m., LVN B said she recalled CR#1. She said on that morning on the 7th ([DATE]), Monday morning, she came in and completed her rounds as normal and spoke to all of her residents. CR#1 was nonverbal, as she came back around the second time, she completed meds and blood sugar. She would ask CR#1 for her hand and say good morning. Sometimes CR#1 grunted or smiled, or sometimes didn't move. She said she held her hand and received her blood and her blood sugar was 56. She said this was alarming for her because it had not been that low for CR#1. She checked CR#1 and she didn't blink, and she removed the covers, and CR#1 didn't move. She called CMA D and instructed her to get the other nurse (LVN C). She wasn't loud because other residents were sleeping, and she didn't want to startle others. She started CPR on CR#1. Then the other nurse came in, LVN C, and they moved CR#1 to the floor and continued CPR and obtained crash cart and called 911. She said LVN C called 911 and got the crash cart. When she checked her blood sugar CR#1 was laying on her side, with her knees up like a semi fetal position. That was how she laid every day. Her bed was in the low position and she had the covers on her, and her head was elevated. She was full code. She said during CPR, she had a blood pressure cuff on her, and the vital readings were not good. She said she completed notes, incident report, and transfer document to take her out of the system. CR#1 didn't go to the hospital. EMS showed up and EMS pronounced her deceased at 8:06 a.m. She said EMS showed up at 7:51 a.m. She said between 7:25 a.m. and 7:30 a.m., somewhere in there, was when she saw CR#1 unresponsive. EMS didn't say or do much of anything. She said she was doing CPR when EMS showed up. The AED was on CR#1 and it kept saying continue CPR. EMS did not do CPR. She said that the palm and the soles of CR#1's feet were pale but not blue. Her hand was in between normal body temp and cool. She said when she started rounds CR#1 looked at her. CR#1 didn't move at that time, but that was normal.<br><br>In a follow up interview on [DATE] at 1:00 p.m. with LVN B she said that when she went to check CR#1's glucose, she had not checked other parts of CR#1's vitals, like blood pressure and pulse. She said she would have checked vitals at the time of giving CR#1's medications. She said she checked sugar first. She said CR#1's sugar were 56, and CR#1 didn't move, so she checked her pulse, and didn't get a pulse. That's why she initiated CPR. She said when LVNC came to room they both did CPR and LVN C then left to get AED and call 911. She said she took the residents blood pressure, and it was ,d+[DATE] or something close to that. The blood pressure was checked during CPR, she put a cuff on CR#1 while doing CPR and hit the button and kept doing CPR.<br><br>In an interview on [DATE] at 1:08 p.m., CMA D said she didn't know what time, but it was around 7 something. She went to go get the other nurse, LVN C. She said the nurse, LVN B, asked her too. She said LVN B and her went to get LVN C. She said they all three met up together at the nurse's station. She then walked back to the med cart and the nurses went to do what they had to do together. She said she didn't know if EMS ever shower up. She said she never went back to check on the resident or ask about her.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on [DATE] at 2:03 p.m., LVN C said he was on duty when CR#1 coded. He said he was working on the other side, CR#1 was not his patient. He said LVN B was the nurse for the other side, for CR#1. He said he was walking out from his hall and LVN B walked out of her hall and informed him at the nursing station she had a code blue. He said they walked down there and the resident was unresponsive and had no pulse. CR#1 was full code and they started CPR. He said he called 911 and brought the crash cart. CPR continued until 911 arrived. AED was applied. LVN B checked vital signs, while he called 911. He wasn't sure what her vitals were, he just knew she had no pulse because he checked her pulse on her neck and wrist. He said her skin was cold when he checked her skin. He said her skin where he checked pulse (pointed to neck and wrist) were fine, but her extremities were cold, her feet were cold. He said he checked CR#1's neck and wrist for a pulse and didn't feel one and then checked on her ankle and didn't feel one, but she felt cold. He said at this time, he worked with the nurse and the male CNA. EMS showed up immediately. He said when EMS took over, he went to an emergency on his hall. He said he was coming from his hall, he saw LVN B rush down the hall, and they met at the nurse station, and then they rushed to the room. CR#1 was in her bed. The resident was under covers when he got into the room. He said he saw the need for CPR based on his assessment of no pulse. He said the only person who told him about the code was LVN B. He said that LVN B reported that CR#1 was unresponsive, she didn't say anything about bs, or other vitals.<br><br>In an interview on [DATE] at 2:40 p.m., the DON said that the nurse, LVN B, called and said that they were finishing up the code for CR#1. LVN B explained that LVN B went into CR#1's room to check blood sugar. She said she checked the sugar, they were low, and when she grabbed her hand to check sugar, the resident would normally grab her hand back but didn't. The LVN B knew something was immediately wrong, and she went ahead called for a code. The paramedics came and when the paramedics were leaving, they told her (DON) that CR#1 already passed prior to arrival. The paramedics didn't say much of anything, and she thought they were coming back in the building because they didn't say anything. She said the paramedics should not have just left her. The LVN B said that whole situation was awkward. She said she called the police and had the police come because she needed the EMT's to come back. They did not come back; the police would not call the EMT's back because they pronounced CR#1 deceased . She said she was called around 5 minutes to 8 by LVN B about finishing up the code. LVN B did not go into details about the situation. She said that she asked her standard questions about the rounds and reporting off to each other at shift change. LVN B reported to the DON, when she checked CR#1's blood sugar she realized she was not breathing. LVN B said her blood sugar were around 58 or 59; something around there. LVN B said she then checked for a pulse and she did not get a pulse at all. She said LVN B did not mention CR#1's blood pressure at all. The nurse that LVN B was working with was LVN C. She said that LVN B said she told CMA D to call LVN C. The nurse should not leave the room, they know to not leave the room. She said at the time of documentation, she (DON) didn't have all the story, but she felt uneasy about what EMS did, so she wanted to make sure it was all documented. She said it was very important for nurses to document everything because in these situations it could be difficult to remember. She said the expectation was that a nurse should stay with resident until EMT's arrive and take over. She said that she read the notes that day ([DATE]) but had not reviewed them since. She said she talked to CMA D, but CMA D didn't have a lot to say. CMA D didn't tell her that they (LVN B and CMA D) walked together to get the other nurse. LVN C reported that she came to get him. She said she doesn't know if it was the nurse or the med aide, she did not ask him who. LVN C reported to her they moved her from bed to floor and placed her on backboard and started CPR. The nurses didn't go in details about who did what and when. She did not ask.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In a follow up in interview on [DATE] at 10:35 a.m., LVN B said when she needed LVN C, she could not remember if she ran to get LVN C or if CMA D got LVN C. She said CR#1 was in the bed when she started CPR, because she couldn't move her to the floor. The bed was already low, so it was easy to do CPR in the bed. She said she didn't know if LVN C checked for the pulse. LVN C got the AED and put the pads on, and CPR was done according to the AED. She said when she started CPR CR#1 was not breathing that's one of the reason she started CPR. The other reason was her low glucose. She said the facility policy was to check the resident, check for pulse, start CPR and call for help. CPR should be initiated when there was no pulse. She said she did not look at the blood pressure cuff for the pulse reading or blood pressure because she checked her carotid for pulse.<br><br>In a follow up interview on [DATE] at 11:12 a.m., LVN C said the facility policy for initiating CPR was the nurses have to alert other nurses by any means necessary. When a patient was unresponsive, and no pulse start CPR. If a patient was unresponsive with a pulse, do not do CPR. CPR was is not done on a patient that was DNR. LVN C said that he called 911 from the nurse's station phone, but he did not announce a code blue status over the intercom to alert anyone else in the building. He said LVN B said that she called a code, but he didn't hear it. He said when LVN B told him CR#1 was unresponsive he called 911 from the nurse station immediately and pushed the crash cart to the room. He said once he entered the room he did not leave the room. He said there was also a male CNA (surveyor identified as CNA A) in CR#1's room as well who was cleaning CR#1 up because she pooped. LVN B came out of the resident's room and said CR#1 was unresponsive, when he got to the room. He repeated, he took the crash cart, joined LVN B in CR#1's room, assisted getting CR#1 down to the floor, and started CPR. CNA A came in room to clean CR#1 during CPR. When AED started everyone had to step back, and then CPR would continue. Surveyor asked LVN C if incontinent care or cleaning of bowel movement should be done on a patient while CPR was in progress? LVN C did not respond. He then said the CNA only moved the blanket because it had poop on it.<br><br>On [DATE] at 12:45 p.m. and 5:14 p.m. messages were left for CNA A.<br><br>In an interview on [DATE] at 1:41 p.m. with the DON and Administrator, the surveyor notified them that it had been reported LVN B and LVN C were doing CPR while a CNA was providing incontinent care. and The DON and Administrator said that CPR and incontinent care should not be occurring simultaneously under any circumstances.<br><br>On [DATE] at 2:08 p.m. the DON and the Administrator returned to the surveyor with LVN C and the Administrator said she wanted LVN C to clarify his initial statement and make sure surveyor understood. LVN C said that CR#1 was in the bed and there was poop all over the sheet. Himself, and LVN B brought CR#1 down to the floor and started CPR. They called CNA A from the hallway and requested him to clean the poop away to make room for CPR. The plan was not incontinent care but for comfortable CPR.<br><br>In an interview on [DATE] at 12:00 p.m., CNA E said she started her shift on [DATE] around 6:30 am. She said she never heard a code being called by any nurse.<br><br>In an interview on [DATE] at 10:27 a.m., CMA D said she didn't hear a code being called, for CR#1, but that doesn't mean it wasn't called. She said she could've been in a resident's room. She said that codes should be called loudly. She said when LVN B informed her about CR#1 being unresponsive, they both left the room to get LVN C. She said she was not delegated a task so she went back to passing medications. She said her responsibility was a med aide and to pass medications.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In a phone interview on [DATE] at 12:12 p.m. CR#1's Family Member said on [DATE] a lady at the nursing home (phone number was DON's according to the employee phone list) called her at 9:01 a.m. and she missed the call. She returned her call at 9:07 a.m. on [DATE] and she (DON) told her the nurses tried to resuscitate CR#1 until paramedics came and took over. She (DON) said the paramedics took over and couldn't resuscitate CR#1 and she passed. She was under the impression that paramedics did CPR.<br><br>Record review of Record of Death for CR#1 revealed the date and time of death was [DATE] at 8:06 a.m. DON completed record on [DATE].<br><br>Record review of EMS Report revealed 911 was called on [DATE] at 7:56 a.m. EMS arrived on scene at 8:03 a.m. EMS arrived at CR#1 at 8:04 a.m. EMS left scene at 8:34 a.m. CR#1 was found lying in the care of healthcare professionals. CR#1 was DOA (dead on arrival). AED was used prior to EMS arrival without defibrillation (without shock). CR#1 was unresponsive with no reactive eye and absent heart beat.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on [DATE] at 11:32 a.m. the DON said she didn't know if LVN B ever told her a time she found CR#1 unresponsive. She just knew she went in to check the residents sugar level. She didn't ask her what time she found her unresponsive. She said she is was trying to get better as far asking questions and learning the role as the DON. She said she passed EMS around 8am when she entered work. She said LVN B reported to her that EMS did not do CPR. CPR should be initiated immediately after a resident was found unresponsive without a pulse. CPR will would not be done if the resident had a pulse. She said she didn't believe that any documentation was falsified, she believed that LVN B documented poorly, and left out details that she should have said, for example the times the events took place. She said she would expect detailed documentation. She said she believed in painting a better timeline and entering exact times. She said she didn't document the note, so she cannot say why a pulse was documented in the same note as the CPR being initiated and 911 being called. She said she believed in sitting down and documenting exactly when it happened. She said she does not know what time EMS was called. She said she believed LVN C called 911. She said 911/EMS should be called immediately when the incident occurs and the nurse is calling for help. When a code is called, the proper procedures are when resident was found unresponsive the nurse or staff should pull the call light, holler for help, send someone to call a code over the intercom for other staff to assist, and whoever is nearest should respond immediately. The responsibility was the person who found the resident unresponsive to delegate the tasks and not leave the resident. The nurse delegating tasks will know someone made the code call because they will hear it over the intercom. A code call should always be done over the intercom. She said she can honestly not say if it was called over the intercom because she was not in the building. She said she began in servicing the staff because there were some things that occurred that should not have occurred, like the nurse leaving the room. The DON said it was her (DON) responsibility to look into the incident to ensure things were done according to policy and also the administrator, if necessary. She said she was continuing to look into the incident, the process started that day and it is still ongoing. She said she didn't ask LVN B Monday ([DATE]) after she read the progress note about CR#1 having a pulse of 101 and then not having a pulse and CPR and 911 being called. She said the lack of information and lack of story is what got her attention and she addressed it with her the next day, on Tuesday, and then yesterday as well. She said she didn't know there was 30 minute delay in calling 911. She said anyone can call 911; a CNA, CMA or other nurse, any staff in the building can call 911 and doesn't have to be delegated by the nurse. She said she has reviewed all of the documents surrounding this incident. She said that there was nothing standing out to her that she didn't already address. She said the family should be notified as soon as being able to, or immediately after the emergency was over. She said this emergency ended when EMS left the building. The nurse should have notified the family when EMS left the building. She said she didn't wait an hour to notify the family. She was in the process of asking LVN B if family and doctor were notified. She said that as soon as she became aware that they were not notified she notified the family.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on [DATE] at 12:06 p.m. the Administrator said she got the call on Monday, [DATE] from the DON about 8:30am and she said that CR#1 coded. The Administrator said that she was just getting in the building and she was upstairs. She said that once she got upstairs, she asked what happened. The DON said that CR#1 coded and EMS didn't take the body. She said that she (administrator) called the police because usually police show up, but EMS already had left the scene. The police called the ME and the body was released. She said that she did talk to LVN B and she reported that she saw CR#1 around 6:20 a.m. making rounds. LVN B said she went back around 7:30 a.m. and when she did the finger stick on CR#1 she didn't pull her finger back as she normally did. LVN B reported that she called her name and received a glucose reading of 59 or so. The Administrator said that LVN B had the blood pressure cuff on her arm. She said that there was no pulse and CR#1 was unresponsive. LVN B started CPR and called over her shoulder to the med aid to call for help. LVN C then came with crash cart and they continued CPR until EMS arrived, but EMS did not take over and EMS pronounced CR#! deceased . She said that she read over the documentation after the incident, she read over everything, well just the nurses notes. She said when she read the note, the Administrator believed that she had a pulse and then didn't have a pulse so CPR was started. She said she talked to the DON about it when they called the police officer. She said she didn't talk to LVN C, CNA A, or CMA D. She said that LVN B was the lead and she was the nurse for CR#1 so she only spoke to LVN B. The expectation is if anyone found a patient unresponsive and without a pulse, they are to call out and hit the call light, begin CPR and the other nurses will come in and assist. She said the staff will go through the steps of the AED and then transfer care to EMS when they arrive. The resident should not be left by herself. She said that they usually holler out or hit the call light and if access to overhead someone on the team can make the overhead call. The CNA's and CMA's held a responsibility to the residents as well, and can notify the nurse and even begin CPR if they were certified. The Administrator said anyone can call out for help. She said 911 should be called as soon as possible, once anyone realized a patient was unresponsive and CPR began. She said everything should happen simultaneously and while CPR was in progress. She said calling 911 30 minutes later is too late. She said that once a resident is found unresponsive without a pulse and code status is checked, CPR should be initiated immediately. The family should be notified once EMS is done at the latest, but the expectation is that someone should be calling 911, calling family, and doctor simultaneously while CPR is in progress. An hour after EMS left the building is considered too late to notify the family. She said she didn't know what time CPR was initiated, because she didn't ask, but the time should be documented. She said that she would assume CPR started shortly right after 7:30 a.m. when LVN B checked sugar. She said LVN B was suspended because of the documentation and the discrepancy of what she reported about the incident. Although, the Administrator said she didn't see anything wrong with what LVN B reported and documented. She said that she didn't feel she need to suspend LVN C because surveyor didn't lead her to believe there was a major concern or discrepancy of the CPR process. The Administrator said she made the decision not suspend to CMA D because she was the one who got the other nurse, LVN C, and then she was not involved anymore. The Administrator said that CMA D could have called 911. She said that she didn't speak with CMA D about the incident. She then said that CMA D said she was in the hall passing medications and didn't see anything. The Administrator said the responsibility is the DON's to ensure compliance with CPR policy and coding. She said that LVN B reported to her that EMS didn't do CPR because she already passed away. The Administrator said she would say it was a shared responsibility with the DON to know what happened to ensure CPR compliance. Surveyor requested that the Administrator notify CNA A of surveyor's calls and request a call back.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In a phone interview on [DATE] at 9:43 a.m. CNA A said that he worked the overnight (10pm to 6am) shift from Sunday ([DATE]th) to Monday ([DATE]th). He said CR#1 was one of his residents. He said he was doing his last round around 5 or 5:30 am, and the nurses, he didn't know their name put a call light on in CR#1's room. He said he put his head in the room and they asked him to come in and said she CR#1 had coded. He said she coded, then they turned on the calllight and they were doing CPR and they asked him to come in the room. Surveyor asked what happened next. CNAA said he didn't touch CR#1, but there was poop on the floor and he didn't touch her. He said he cleaned the area so they can do CPR on her. He said they didn't stop performing CPR. He said when he put his head in the room he was asked to clean the area and pull the sheet off of the bed and the sheet is was what he used to clean the area. He said this was around 5 to 530 am. He said he knows for sure because he was in the midst of doing his last round and he can say that without a doubt. He said he didn't hear anyone call for a code. He just saw the light on and that's what got his attention. He said after he cleaned the BM the nurses didn't instruct him to do anything else, so he just left the room. He said that if he hears a code, and he was in the general area he is was to go to the room and ask what he needs to do. He said he was CPR certified so he could take over if needed. He said the nurses were doing their thing (CPR). He said he never heard a code called. He said he did eventually see EMS come in the building because he physically saw them coming in the building. He said he was unsure if EMS came around the same time as the CPR being performed.<br><br>In an interview on [DATE] at 3:51 p.m., Resident #2 said she was CR#1's roommate. She said she remembered her. She said that she leaves the facility around 8 something to go to dialysis on Mondays. She said she remembered the morning her roommate (CR#1) passed away. She said that the nurse that was for her side (LVN B) came in and then said she had to go get the other nurse (LVN C). This was around 7 something. She then she came back with the other nurse and they brought the cart to do CPR. She said the nurse (LVN B) came in around 7 something and this was the first time she came in the room that morning. She said she went to the dining around 7 am, then went back to her room and then that's when LVN B came to the room or the first time. Resident #2 said before she went to the dining room that morning LVN B didn't enter her room. Surveyor asked Resident #2 if she asked a CNA for assistance that morning. She said for what? She said she didn't need any assistance from any nurse; she dresses herself, makes her bed and does everything for herself. She said she didn't see the med aide that morning. She said CR#1 was in the bed when LVN C came to the room with the crash cart. She said that before LVN B left to go get LVN C, she did not do CPR on CR#1. She said she was asked to leave the room when LVN C came with the cart. She said then a male CNA went into the room with an adult brief brief.<br><br>In an interview on [DATE] at 12:35 p.m. LVN B said CR#1 pooped and it came out of the adult brief brief and was on the draw sheet when she was placed on the floor. LVN C requested an aide come clean her up. The CNA entered, took off the adult brief brief and wiped her during CPR and then placed a new adult brief brief on her. There was not poop all around the floor, it was only on the draw sheet. She continued CPR throughout the whole time.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of facility's Cardiopulmonary Resuscitation Policy dated [DATE] revealed the responsibility of CPR belonged to a licensed nurse and any person in the facility with CPR expertise. The purpose is to ventilate and establish circulation on a patient with absence of respirations and pulse. Procedure is to determine unresponsiveness, call out for help and press call light, delegate specific individual to check patient medical record/care plan for CPR or no CPR order and report back immediately, have individual call paramedics, attending physician, and administrative personnel per facility policy and report back to you as soon as possible, do not start CPR if patient is breathing and has a pulse, position patient by turning on back supporting head and neck, open airway, determine respiratory status, determine pulselessness, delegate a specific individual to check on status of paramedics, and continue CPR until relieved by another qualified person; i.e paramedic or a physician pronounces the patient dead and gives orders to discontinue CPR. CPR documentation should include date and exact time condition changed was observed, vital signs or absence of vitals signs, exact time CPR was started, exact time paramedics were notified, exact time paramedics arrived, exact time attending physician was called and exact time reached, notification of patient's family or responsible party .and complete documentation with the signature and title of licensed nurse.<br><br>Record review of Facility's Resident Advanced Directives dated [DATE] revealed the facility had 83 residents as a full code status.<br><br>This was determined to be an Immediate Jeopardy (IJ) situation on [DATE] at 2:52 p.m. The Corporate Nurse, Administrator and DON were notified and a plan of removal was requested. The Administrator was provided an Immediate Jeopardy template on [DATE] at 2:52 p.m.<br><br>The following Plan of Removal was submitted and accepted on [DATE] at 1:25 a.m.:<br><br>Immediate Jeopardy<br><br>Plan of Removal<br><br>[DATE]<br><br>Immediate action:<br><br>Medical Director was notified on [DATE] at 3:00pm<br><br>Emergent QAPI meeting was conducted on [DATE]<br><br>Root-cause identified that re-education of the CPR process was needed.<br><br>Systematic Approach:<br><br>1. The facility suspended LVN A on [DATE] pending completion of a thorough investigation. If suspended staff are able to return post investigation prior to returning to the floor will be in-serviced on CPR process.<br><br>2. The facility Social Worker conducted an audit on [DATE] verifying residents' charts contained the correct code status. Facility has 83 Full-Code status<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 3. The facility HR conducted an audit on [DATE] verifying licensed nursing staff files contain current CPR certification. Facility has set-up CPR Training Courses for [DATE] and [DATE] for all Clinical staff and available for all employees. RN/LVN are required to be CPR certified<br><br>4. Nurse Management will conduct Mock codes from [DATE] to [DATE] ensuring lifesaving procedures are understood and followed. DON will continue to schedule on monthly basis. RNs, LVN's, CMA's and CNA's participated in the mock codes. Proper execution of CPR steps and utilization of AED machine will be reviewed in the mock code. Any deficient practice will be corrected and reported to the ED immediately and all findings will be discussed in the monthly/and as necessary.<br><br>5. Beginning [DATE] to [DATE] and will continue until 100% of nursing staff has been in-serviced by DON. Unit Manager and Designee on the following topics: Clinical staff will not be allowed to work after [DATE] prior to completing below in-serv [TRUNCATED] |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870<br><br>Based on observation, interview and record review, the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (CR #1) reviewed for Administration, in that:<br><br>-The administration failed to ensure staff documented accurately and appropriately for CPR, and timely notification of family and physician of change in condition for CR#1.<br><br>-The administration failed to report and investigate the death of CR#1 when allegations that CR#1 was cold, stiff, and found deceased in the facility were made by licensed nurses.<br><br>The administration failed to ensure staff implemented and provided care and services to CR#1 in accordance with facility policies and procedures for CPR.<br><br>The administration failed to allow State Surveyor to complete investigation without interference by discussing with the staff the interview questions and directing LVN B and LVN C on the investigation.<br><br>These failures could affect all residents placing them at risk of the facility not being administered in a way to assist with physical, mental, and psychosocial needs.<br><br>Findings include:<br><br>CR#1<br><br>Record review of CR#1's face sheet revealed CR#1 was a [AGE] year-old female resident admitted to the facility on [DATE]. CR#1 was discharged at the time of death on [DATE] at 8:06 am. CR#1's diagnosis included cerebrovascular disease (stroke), dementia (memory loss), Diabetes Type ll (resists insulin), conversion disorder with seizures or convulsions (non-epileptic seizures), chronic kidney disease (kidney failure), and contracture of left and right knee (knee unable to fully extend).<br><br>Record review of CR#1 Comprehensive MDS assessment dated [DATE] revealed CR#1 had a BIMS score of 11 indicating moderately impaired cognition. CR# required extensive assistance by one-person physical assist for all ADLs. CR#1 was incontinent to bowel and bladder. CR#1 had a g-tube.<br><br>Record review of CR#1s Care plan dated ,d+[DATE] through present revealed CR#1 was full code status.<br><br>Record review of Progress Note dated [DATE] revealed LVN B entered note on [DATE] at 8:55 a.m. that read, went in to speak to patient during rounds, although patient is nonverbal. Left out of room when informed by another CNA another patient (roommate) needed my assistance in the dining room. Note effective date and time of the occurrence was [DATE] at 6:30 a.m.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Progress Notes dated [DATE] revealed LVN B entered note on [DATE] at 9:07 a.m. that read, When going to do blood sugar and give meds, I spoke to patient and told her I need to do her blood sugar, as normal sometimes she will respond, I took her hand to do the blood sugar and after I stuck her and got the blood, the reading was 59 and a BP of ,d+[DATE] with a pulse of 101, I noticed she did not respond as usual. I then shook patient and called out her name again with no response. Then 911 was immediately called. I then pulled back the covers and still got response, I then check for a pulse and got no pulse, then CPR was started. The med aide was called from the hallway for help, I instructed her to get the other nurse while continuing CPR. Upon the other nurse coming in, he went to get crash cart, when he returned, the patient was placed on the floor on a backboard and CPR was continued until EMS arrived, case was then transferred to EMS. Effective date and time of occurrence was [DATE] at 8:55 a.m.<br><br>Record review of SBAR Communication Form completed by LVN B on [DATE] at 9:22 a.m. revealed CR#1's symptoms of low vitals began on [DATE]. Things that make the symptom better are CPR. Vitals were documented as: Pulse- 101; blood sugar- 59; BP- ,d+[DATE]. CR#1 had decreased level of consciousness, decreased mobility, no changes in respiratory evaluation, and resting pulse greater than 100. Observation and evaluation were summarized as patient not a normal baseline, vital signs taken (BP ,d+[DATE], P-101, BS-59), patient not responding, CPR started. Physician and family notified at 9:00 am on [DATE].<br><br>In an interview on 3//,d+[DATE] at 11:15 a.m. with LVN F, she said she was not on duty on [DATE] but she heard CR#1 expired. She said that she was not on hospice. LVN F said that her death was not expected, but she had declined. She said that CR#1 had history of unstable blood sugar, it was somewhat her baseline. She said that prior to hospitalization in January, she was trending low on blood sugar, and then after she was readmitted , she was trending higher.<br><br>In an interview on [DATE] at 12:33 p.m., CR#1's Physician said that the facility notified him of CR#1's passing. He said they reported finding her unresponsive and she passed way. He said that they mentioned doing CPR. He said she went to the hospital (middle of [DATE]) for blood sugar fluctuating, but she got back and had been stable. He said the death was a surprise to him as she was stable. She was a sick resident with issues, so he would not say the death was unexpected. He said CR#1 was doing ok. She appeared to be at baseline. Hospice was not considered for CR#1.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on [DATE] at 11:25 a.m., LVN B said she recalled CR#1. She said that on that morning on the 7th ([DATE]), Monday morning, she came in and completed her rounds as normal and spoke to all of her residents. CR#1 was nonverbal, as she came back around the second time, she completed meds and blood sugar. She would ask CR#1 for her hand and say good morning. Sometimes CR#1 grunted or smiled, or sometimes didn't move. She said she held her hand and received her blood and her blood sugar was 56. She said this was alarming for her because it had not been that low for CR#1. She checked CR#1 and she didn't blink, and she removed the covers, and CR#1 didn't move. She called CMA D and instructed her to get the other nurse (LVN C). She wasn't loud because other residents were sleeping, and she didn't want to startle others. She started CPR on CR#1. Then the other nurse came in, LVN C, and they moved CR#1 to the floor and continued CPR and obtained crash cart and called 911. She said LVN C called 911 and got the crash cart. When she checked her blood sugar CR#1 was laying on her side, with her knees up like a semi fetal position. That was how she laid every day. Her bed was in the low position and she had the covers on her, and her head was elevated. She was full code. She said during CPR, she had a blood pressure cuff on her, and the vital readings were not good. She said she completed notes, incident report, and transfer document to take her out of the system. CR#1 didn't go to the hospital. EMS showed up and EMS pronounced her deceased at 8:06 a.m. She said EMS showed up at 7:51 a.m. She said between 7:25 a.m. and 7:30 a.m., somewhere in there, was when she saw CR#1 unresponsive. EMS didn't say or do much of anything. She said that she was doing CPR when EMS showed up. The AED was on CR#1 and it kept saying continue CPR. EMS did not do CPR. She said that the palm and the soles of CR#1's feet were pale but not blue. Her hand was in between normal body temp and cool. She said when she started rounds CR#1 looked at her. CR#1 didn't move at that time, but that was normal.<br><br>In an interview on [DATE] at 11:50 a.m.; CMA D said before 8am, around 7 something on [DATE], LVN B said come here for a minute and witness this. She said that CR#1 was cold. CMA D said that she didn't touch CR#1 but LVN B said CR#1 was cold She said that her and LVN B went to get LVN C.<br><br>In a follow up interview on [DATE] at 1:00 p.m. with LVN B she said that when she went to check CR#1's glucose, she had not checked other parts of CR#1's vitals, like blood pressure and pulse. She said she would have checked vitals at the time of giving CR#1's medications. She said she checked the residents sugar levels first. She said CR#1's sugar was 56, and CR#1 didn't move, so she checked her pulse, and didn't get a pulse. That's why she initiated CPR. She said she hollered at CMA D from the door and told her to get a nurse. She said when LVNC came to the room they both did CPR and LVN C then left to get AED and call 911. The DON called the family. She said she took the residents blood pressure, and it was , d+[DATE] or something close to that. The blood pressure was checked during CPR, she put a cuff on CR#1 while doing CPR and hit the button and kept doing CPR. She said she did not tell CMA D that CR#1 was cold.<br><br>In an interview on [DATE] at 1:08 p.m., CMA D said she didn't know what time, but it was around 7 something. She went to go get the other nurse, LVN C. She said the nurse, LVN B, asked her too. She said LVN B and her went to get LVN C. She said they all three met up together at the nurses station. She then walked back to the med cart and the nurses went to do what they had to do together. She said she didn't know if EMS ever showered up. She said she never went back to check on the resident or ask about her.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on [DATE] at 1:50 p.m. LVN H said he worked with CR#1 on [DATE] evening through the morning on [DATE] and left around 6:15 am. He said he was told that CR#1 passed away. He was told on his way in this afternoon when [NAME] was told Surveyor wanted to speak with him about her. He said no one had talked to him previously. He said CR#1 had covid and seemed to have declined she wouldn't get out of bed and didn't talk. He said that on ,d+[DATE] overnight shift, he changed all of her g-tube equipment out. He said he did the breathing treatment for CR#1 on [DATE] at 5am. He said he checked her vitals, temperature, respirations, and pulse. He said all were normal for her baseline.<br><br>Record review of [DATE] Medication Administration record for CR#1 revealed on [DATE] at 6am an order for albuterol sulfate 0.63 mg/3 mL solution for nebulization every 6 hours was completed by LVN H. CR#1 vitals recorded were pretreatment pulse was 75, pretreatment pulse ox was 97, and pretreatment respirations were 18, and minutes of treatment was 15. Post treatment pulse was 75, post treatment pulse ox was 97, and post treatment respirations were 18.<br><br>In an interview on [DATE] at 2:03 p.m., LVN C said he was on duty when CR#1 coded. He said he was working on the other side, CR#1 was not his patient. He said LVN B was the nurse for the other side, for CR#1. He said he was walking out from his hall and LVN B walked out of her hall and informed him at the nursing station she had a code blue. He said they walked down there, and the resident was unresponsive and had no pulse. CR#1 was full code and they started CPR. He said he called 911 and brought the crash cart. CPR continued until 911 arrived. AED was applied. LVN B checked vital signs, while he called 911. He wasn't sure what her vitals were, he just knew she had no pulse because he checked her pulse on her neck and wrist. He said her skin was cold when he checked her skin. He said her skin where he checked the pulse (pointed to neck and wrist) were fine, but her extremities were cold, her feet were cold. He said he checked CR#1's neck and wrist for a pulse and didn't feel one and then checked on her ankle and didn't feel one, but she felt cold. He said at this time, he worked with the nurse and the male CNA. EMS showed up immediately. He said when EMS took over, he went to an emergency on his hall. He said he was coming from his hall, he saw LVN B rush down the hall, and they met at the nurse station, and then they rushed to the room. CR#1 was in her bed. The resident was under covers when he got into the room. He said he saw the need for CPR based on his assessment of no pulse. He said the only person who told him about the code was LVN B. He said that LVN B reported that CR#1 was unresponsive, she didn't say anything about bs, or other vitals.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on [DATE] at 2:40 p.m., the DON said the nurse, LVN B, called and said they were finishing up the code for CR#1. She explained she went into her room to check blood sugar. She said she checked CR #1's sugar, they were low, and when she grabbed her hand to check sugar, the resident would normally grab her hand back but didn't. The LVN B knew something was immediately wrong, and she went ahead called for a code. The paramedics came and when the paramedics were leaving, they told her (DON) CR#1 already passed. The paramedics didn't say much of anything, and she thought they were coming back in the building because they didn't say anything. She said the paramedics should not have just left her. The nurse said that whole situation was awkward. She said she called the police to have the police come because she needed the EMTs to come back. They did not come back; the police would not call the EMT's back because they pronounced CR#1 deceased . She said that she was called around 5 minutes to 8 by LVN B about finishing up the code. LVN B didn't go in details about the situation. She said she asked her standard questions about the rounds and reporting off to each other at shift change. LVN B reported to the DON that she checked CR#1's blood sugar she realized she wasn't breathing. LVN B said her blood sugar was around 58 or 59; something around there. LVN B said she then checked for a pulse and she did not get a pulse at all. She said LVN B did not mention CR#1's blood pressure at all. The nurse that LVN B was working with was LVN C. She said LVN B said she told CMA D to call LVN C. The nurse should not leave the room, they know to not leave the room. She said that she did not assist LVN B with her documentation, but she made sure that LVN B put in a note. She said at the time of the documentation, she (DON) didn't have all of the story, but she felt uneasy about what EMS did, so she wanted to make sure it was all documented. She said it is very important for nurses to document everything because in these situations it can be difficult to remember. She said the expectation is that a nurse should stay with resident. She said that she read the notes that day ([DATE]) but haven't reviewed them since. She said she talked to CMA D, but CMA D didn't have a lot to say. CMA D didn't tell her that they (LVN B and CMA D) walked together to get the other nurse. LVN C reported that she came to get him. She said she doesn't know if it was the nurse or the med aide, she did not ask him who. LVN C reported to her that they moved her from bed to floor and placed her on backboard and started. The nurses didn't go in details about who did what and when. She did not ask. She said that she did speak with CMA D and she didn't report that CR#1 was cold and already deceased . DON said that CMA D didn't tell her that she and LVN B walked to nurses' station to get LVN C. DON said that she helped with post mortem care and she helped to raise CR#1 back in the bed. She said CR#1 is always cold to touch, she had poor circulation. She said she was always cold. She said herself and LVN B were on speaker phone to family.<br><br>(continued on next page) |

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|---|---|---|---|
| | 675423 | A. Building<br>B. Wing | 03/21/2022 |

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| Ashford Gardens | 7210 Northline Dr<br>Houston, TX 77076 |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a follow up in interview on [DATE] at 10:35 a.m., LVN B said when she started her shift at 6am on [DATE] the first thing she did was clock in and screen and then she came up to second floor and put her things down. She said when she got down to CR#1's room, on the 2300 hall, she didn't know who it was, but she said someone came in and said someone needed her at the dining room upstairs. She said it was Resident #2 that she went to check on in the dining. She said then she came back and finished rounds with other residents and took report from the nurse she relieved (LVN H). She said then she started rounds and passing meds. She said she didn't know what time she started rounds, but CR#1 was one of the last residents she does meds and blood sugar checks for because she was had a g-tube and didn't go to dining room for breakfast. She said on Monday, [DATE], she got back to CR#1 between 7:20 a.m. and 7:30 a.m. She said per physician orders her insulin and sugar should be checked at 6:30 a.m., but she had an hour before and after, so she has from 5:30 a.m. to 7:30 a.m. to check sugar and give insulin. She said she took her blood pressure during CPR. She said she put the cuff on her arm and never looked at the reading. She started doing what she was doing (CPR) and then after everything was said and done, she remembered she put the cuff on her arm and took the reading from the cuff. She took the blood pressure before CPR started but didn't know the reading until afterwards because she immediately started CPR. CR#1 pulse was taken by the cuff as well. She said she cannot say yay or nay to putting the cuff on before she started CPR or not. She said she started CPR because she wasn't responding, and she checked pulse on her carotid and then her groin and didn't get pulse so then she started CPR. She then ran to the door and called for CMA D her for her help. She said when she needed LVN C, she cannot remember if she ran to get LVN C or if CMA D got LVN C. She said CR#1 was in the bed when she started CPR, because she couldn't move her to the floor. The bed was already low, so it was easy to do CPR in the bed. She said she didn't know if LVN C checked for the pulse. She said she was in the middle of CPR when LVN C came to the room. LVN C got the AED and put the pads on, and CPR was done according to the AED. She said when she started CPR, she was not breathing that's one of the reasons she started CPR. The other reason was her low glucose. She said the facility policy is was to check resident, check for pulse, start CPR and call for help. CPR should be initiated when there was no pulse. She said she did not look at the blood pressure cuff for the pulse reading or blood pressure because she checked her carotid for pulse. She said she didn't know what she reported to the surveyor that she didn't check vitals the first time. She said she couldn't remember what she reported to the surveyor. Surveyor asked LVN B if the blood pressure cuff was placed on CR#1 prior to CPR as she documented a pulse of 101 from the cuff, then this would mean CR#1 had a pulse and CPR was not needed. She said the pulse could have been a reading during CPR process because she didn't have a pulse before CPR. LVN B then said the AED was on CR#1 during CPR, so she didn't run the blood pressure cuff during CPR.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a follow up interview on [DATE] at 11:12 a.m., LVN C said the facility policy for initiating CPR was the nurses have to alert other nurses by any means necessary. When a patient is unresponsive, and no pulse start CPR. If a patient was unresponsive with a pulse, do not do CPR. CPR was not done on a patient that is was DNR. He said he checked CR#1's pulse during CPR and there was not a pulse. He said he grabbed the crash cart on the way to the room, he didn't go to the room and then leave to get the crash cart. He said LVN B did the oxygen. he said the blood pressure cuff will give the pulse. There was no pulse. He said the blood pressure cuff was in LVN B's hands when he entered the room, it was placed on CR#1 wrist during CPR, and then it was checked during CPR. There was not a reading for blood pressure or pulse on the blood pressure cuff during CPR. He said CPR would have stopped if there was a pulse. The AED also gave direction on CPR process. He said they follow AED commands. Once the AED was on, they did not use the blood pressure cuff. They followed AED command to stay clear. LVN C said that he called 911 from the nurse's station phone, but he did not announce a code blue status over the intercom to alert anyone else in the building. He said LVN B said that she called a code, but he didn't hear it. He said LVN B told him CR#1 was unresponsive he called 911 from the nurse station immediately and pushed crash cart to the room. He said once he entered the room he did not leave the room. He said there was also male CNA (surveyor identified as CNA A ) that was in CR#1's room as well. He was cleaning CR#1 up because she pooped. LVN B came out of resident's room and said CR#1 was unresponsive when he got to the room, He repeated, he took the crash cart, joined LVN B in CR#1's room, assisted getting CR#1 down to the floor, and started CPR. CNA A came in the room to clean CR#1 during CPR. When the AED started everyone had to step back, and then CPR would continue. Surveyor asked LVN C if incontinent care or cleaning of bowel movement should be done on a patient while CPR was in progress? LVN C did not respond. He then said the CNA only moved the blanket because it had poop on it.<br><br>In an interview on [DATE] at 11:31 a.m. CNA G said that she worked the 2p to 10pm shift on Sunday [DATE]. She stated she was asked by a man she cannot remember who he was, but the man came up to her and asked her about her shift on the 2 to 10 pm on Sunday, the 6th. She said she assisted with CR#1, and she was alert and awake. CR#1 even cried tears after being called princess by another aide who does it often. This happened after trays were already pulled so it was around 8:30 p.m. She said she didn't know what happened to CR#1 but whatever happened, happened on the 10pm to 6am shift or 6am to 2pm shift on the 7th. She said that she heard that CR#1 was found dead and unresponsive. She worked Monday on the 7th the 6am to 10pm shift. She said she worked upstairs. She said she got to work late that day around 7am on Monday, the 7th., and was on 2100 hall to 2205 hall. She said she went downstairs and to get linen. She sadi when she came back to the second floor, the social worker came up to her and asked if she could assist with a resident in a room with no clothes on. The oOn the hallway was all the nurses, and the Administrator. It was around between 7:30 am and 8am, and the ambulance was outside the building as well. She said she was certain she saw the administrator and certain she was outside CR#1's room because she passed the room to get to the resident's room she needed to help. She said most of them were in the room, but the administrator had walked out of the room into the hallway. This was between 7:30 am and 8am.<br><br>On [DATE] at 12:45 p.m. and 5:14 p.m. messages were left for CNA A.<br><br>In an interview on [DATE] at 1:41 p.m. with the DON and Administrator, the surveyor notified them that it had been reported LVN B and LVN C were doing CPR while a CNA was providing incontinent care. and The DON and Administrator said that CPR and incontinent care should not be occurring simultaneously under any circumstances.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 2:08 p.m. the DON and the Administrator returned to the surveyor with LVN C and the Administrator said that she wanted LVN C to clarify his initial statement and make sure the surveyor understood. LVN C said CR#1 was in the bed and there was poop all over the sheet. Himself, and LVN B brought CR#1 down to the floor and started CPR. They called the CNA A from the hallway and requested him to clean the poop away to make room for CPR. The plan was not incontinent care but for comfortable CPR.<br><br>In an interview on [DATE] at 12:00 p.m., CNA E said she started her shift on [DATE] around 6:30 am. She said she never heard a code being called by any nurse.<br><br>In an interview on [DATE] at 10:27 a.m., CMA D said she didn't hear a code being called, for CR#1, but that doesn't mean it wasn't called. She said she could've been in a room. She said that codes should be called loudly. She said when LVN B informed her about CR#1 being unresponsive, they both left the room to get LVN C. She said she was not delegated a task, so she went back to passing medications. She said her responsibility was a med aide and to pass medications.<br><br>In a phone interview on [DATE] at 12:12 p.m. CR#1's Family Member said that on [DATE] a lady at the nursing home (phone number is was DON's) called her at 9:01 a.m. and she missed the call. She returned her call at 9:07 a.m. on [DATE] and she (DON) told her the nurses tried to resuscitate CR#1 until paramedics came and took over. She (DON) said the paramedics took over and couldn't resuscitate CR#1 and she passed. She was under the impression that paramedics did CPR.<br><br>Record review of Record of Death for CR#1 revealed the date and time of death was [DATE] at 8:06 a.m. DON completed the record on [DATE].<br><br>Record review of EMS Report revealed 911 was called on [DATE] at 7:56 a.m. EMS arrived on scene at 8:03 a.m. EMS arrived at CR#1 at 8:04 a.m. EMS left scene at 8:34 a.m. CR#1 was found lying in the care of healthcare professionals. CR#1 was DOA (dead on arrival). AED was used prior to EMS arrival without defibrillation. CR#1 was unresponsive with no reactive eye and absent heart beat.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on [DATE] at 11:32 a.m. the DON said that she didn't know if LVN B ever told her a time she found CR#1 unresponsive. She just knew she went in to check the residents sugar. She didn't ask her what time she found her unresponsive. She said she is trying to get better as far asking questions and learning the role as DON. She said she passed EMS around 8am when she entered work. She said LVN B reported to her that EMS did not do CPR. CPR should be initiated immediately after a resident was found unresponsive without a pulse. CPR would not be done if the resident had a pulse. She said she didn't believe that any documentation was falsified, she believed that LVN B documented poorly, and left out details that she should have said, for example the times the events took place. She said she would expect detailed documentation. She said she believed in painting a better timeline and entering exact times. She said she didn't document the note, so she cannot say why a pulse was documented in the same note as the CPR being initiated and 911 being called. She said she believed in sitting down and documenting exactly when it happened. She said she does not know what time EMS was called. She said she believed LVN C called 911. She said 911/EMS should be called immediately when the incident occurs, and the nurse is calling for help. When a code was called, the proper procedures are when resident is was found unresponsive the nurse or staff should pull the call light, holler for help, send someone to call a code over the intercom for other staff to assist, and whoever is was nearest by should respond immediately. The responsibility was the person who found the resident unresponsive to delegate the tasks and not leave the resident. The nurse delegating tasks will know someone made the code call because they will hear it over the intercom. A code call should always be done over the intercom. She said she can honestly not say if it was called over intercom because she was not in the building. She said she began in servicing the staff because there were some things that occurred that should not have occurred, like the nurse leaving the room. The DON said it was her (DON) responsibility to look into the incident to ensure things were done according to policy and also the administrator, if necessary. She said she was continuing to do that; the process started that day and it was still ongoing. She said she didn't ask LVN B Monday ([DATE]) after she read the progress note about CR#1 having a pulse of 101 and then not having a pulse and CPR and 911 being called. She said the lack of information and lack of story is what got her attention and she addressed it with her the next day, on Tuesday, and then yesterday as well. She said she didn't know there was a 30-minute delay in calling 911. She said anyone can call 911; a CNA, CMA or other nurse, any staff in the building can call 911 and doesn't have to be delegated by the nurse. She said she has reviewed all of the documents surrounding this incident. She said that there was nothing standing out to her that she didn't already address. She said the family should be notified as soon as being able to, or immediately after the emergency was over. She said this emergency ended when EMS left the building. The nurse should have notified the family when EMS left the building. She said she didn't wait an hour to notify the family. She was in the process of asking LVN B if family and doctor were notified. She said that as soon as she became aware that they were not notified she notified the family. She said the incident did require reporting to the state, so it was reported. She said the nurses lack of documentation was addressed. She said she went back yesterday and found that there was not any additional documentation and she could have done an addendum. She said she felt it was state reportable because it involved the death of a resident. She said incidents should be reported to the state as soon as possible, or immediately or as soon as other details make it not the norm. She said it's a feeling not really anything specific to verbalize as to why she thinks this should've been reported to the state. She said LVN B was on suspension due to the pending investigation surrounding the emergency that occurred on Monday [DATE]. She was referring to the facility investigation that was reported on [DATE]. She said that they are continuing to look into the matter. She said the decision to suspend LVN B and not LVN C or CMA D was the administrator's decision. She said she assisted the staff to get CR#1 back on the bed after she passed. She had stool on her bottom, she had her AED pads still on. She said her neck was hyperextended so they propped her neck so she would have support. She was always a little cold, but she was surprised the back of her knees was quite warm. She has always been contracted so she was stiff in that sense, but she was not hard. There was no pooling.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on [DATE] at 12:06 p.m. the Administrator said she got the call on Monday, [DATE] from the DON about 8:30am and she said CR#1 coded. The Administrator said she was just getting in the building and she was upstairs. She said once she got upstairs, she asked what happened. DON said CR#1 coded and EMS didn't take the body. She said she (administrator) called the police because usually police show up, but EMS had already left the scene. The police called the ME and the body was released. She said she did talk to LVN B and she reported she saw CR#1 around 6:20 a.m. making rounds. LVN B said she went back around 7:30 a.m. and when she did the finger stick on CR#1 she didn't pull her finger back as she normally did. LVN B reported she called her name and received a glucose reading of 59 or so. The Administrator said LVN B had the blood pressure cuff on her arm. She said that there was no pulse and CR#1 was unresponsive. LVN B started CPR and called over her shoulder to the med aide to call for help. LVN C then came with crash cart and they continued CPR until EMS arrived, but EMS did not take over and EMS pronounced CR#1 deceased . She said that she read over the documentation after the incident, she read over everything, well just the nurses notes. She said when she read the note, the Administrator believed that she had a pulse and then didn't have a pulse, so CPR was started. She said she talked to the DON about it when they called the police officer. She said she didn't talk to LVN C, CNA A, or CMA D. She said that LVN B was the lead, and she was the nurse for CR#1, so she only spoke to LVN B. The expectation was if anyone found a patient unresponsive and without a pulse, they are to call out and hit the call light, begin CPR and the other nurses will come in and assist. She said the staff will go through the steps of the AED and then transfer care to EMS when they arrive. The resident should not be left by herself. She said that they usually holler out or hit the call light and if access to overhead someone on the team can make the overhead call. The CNA's and CMA's held a responsibility to the residents as well, and can notify the nurse and even begin CPR if they were certified. The Administrator said anyone can call out for help. She said 911 should be called as soon as possible, once anyone realized a patient was unresponsive and CPR began. She said everything should happen simultaneously and while CPR was in progress. She said calling 911 30 minutes later was too late. She s [TRUNCATED] |

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| F 0839<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Employ staff that are licensed, certified, or registered in accordance with state laws.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870<br><br>Based on record review and interview the facility failed to ensure 1 of 7 staff reviewed for staff qualifications (CNA A), were licensed, certified, or registered in accordance with applicable State laws, in that:<br><br>CNA A nursing license, expired on [DATE] and he continued to provide care to facility residents.<br><br>This failure could result in residents being provided care by staff who were not currently qualified per state laws.<br><br>Findings Included:<br><br>Record review of CNA A's employee file revealed his license expired on [DATE].<br><br>Record review of the Nurse Aid Registry revealed CNA A license expired on [DATE].<br><br>Record review of Facility scheduled dated [DATE]st through [DATE]th revealed CNA A was scheduled for [DATE]rd, 4th, 5th, 6th, 7th, and 9th.<br><br>Record review of CNA A Time Sheets dated [DATE]th through [DATE]th revealed CNA A worked overnight on [DATE], and [DATE].<br><br>In an interview on [DATE] at 2:48 p.m. the Administrator said she was not aware CNA A license was expired until today ([DATE]) when she brought the requested employee file. She said that the aides were responsible for ensuring their license was current. She said she thought HR pulled licenses monthly but was not sure.<br><br>In an interview on [DATE] at 9:43 a.m., CNA A said he completed his paperwork to renew his license last week. He said his CNA license was inactive. It expired the second of this month. ([DATE]).<br><br>In an interview on [DATE] at 4:22 p.m., HR said it was her responsibility to keep track of all licenses. She said that she would check monthly and inform employee about license expiring. She said she informed CNA A in February 2022. She said she had to wait on his completed training. She said a staff with an expired licensed was not allowed to work. She said CNA A was removed from schedule on [DATE].<br><br>Record review of Facility Nurse Aide Employment Verification (form 5509-NAR) dated 3//,d+[DATE] revealed CNA A was listed as an employee needing a license renewal.<br><br>Record review of the Facility's Certified Nursing Assistant Job Description dated 2017 revealed state certification is mandatory. |