STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. BUILDING _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERCOMMUNITY CARE CENTER	2626 GRAND AVENUE LONG BEACH, CA 90815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 1 support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the nursing staff immediately initiate basic life support ([BLS] care healthcare professionals provide to anyone who's heart stops beating suddenly) including ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) to one of three sampled residents (Resident 1), who became unresponsive on 7/26/2024 while in the dining room. The facility failed: 1. Ensure the Licensed Vocational Nurse (LVN 3) did not instruct Certified Nursing Assistant (CNA 5) to wheel Resident 1 out from the dining room back to Resident 1's room so that CPR could be provided in the resident's room. 2. Ensure LVN 3 and CNA 5, when they found Resident 1 unresponsive, did not waist critical time by placing Resident 1 on his wheelchair then wheeling the resident back to his room, and transferring the resident on his bed instead of immediately initiating CPR. 3. Ensure the nursing staff initiated lifesaving measures, including CPR, immediately when Resident 1 was found unresponsive and pulseless.	F 678	On 07/12, 13, and 17, 2024, the Director of Nursing (DON) and Director of Staff Development (DSD) provided an in-service regarding the emergency management of a resident in cardiopulmonary arrest. On 07/15/2024, the Director of Staff Development (DSD) conducted an audit on Registered Nurse (RNs), Licensed Vocational Nurses (LVNs) and Certified Nurse Assistants (CNAs) for the current Basic Life Support (BLS) Certification. Based on the record. ! RN, 1 LVN, and 2 CNAs must be re-certified. On 07/16/2024, the Director of Nursing (DON) coordinated with an accredited Basic Life Support (BLS) Instructor, an outside provider, to provide in-service, educate, and conduct a competency skills assessment for the nurses staff as in compliance with the American Heart Association. On 07/18/2024, the American Heart Association Basic Life Support Instructor will provide the recertification training to the listed nursing staff: One (1) RN, one (1) LVN, and two (2) CNAs will attend the training.	Completion Date: 07/12,13, and 17, 2024 Completion Date: 07/16/2024 Completion Date: 07/18/2024 Completion Date: 07/15/2024 ADDENDUM 07/18/2024

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F 678	Continued From page 2 4. Ensure staff called 911 as soon as Resident 1 was found unresponsive. As a result, there was an eight-minutes delay in starting Resident 1's CPR. Resident 1 was pronounced dead on 7/6/2024, at 6:03 p.m. These deficient practices placed 58 residents, who had a Full Code (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) status at risk not to receive life saving measures timely, including CPR. On 7/12/2024 at 3:24 p.m., the Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of Administrator (ADM),the Director of Nursing (DON) due to the facility's failure to provide timely basic life support (BLS) to Resident 1, including immediate initiation of CPR. An IJ Removal Plan ([IJRP], an intervention to immediately correct the deficient practices) was requested. On 7/16/2024 at 4.25 p.m., the ADM submitted an acceptable IJRP. After onsite verification of IJRP implementation through observation, interview, and record reviews, the IJ was removed on 7/16/2024 at 5:45 p.m., in the presence of the ADM, the DON, and Director of Staff Development (DSD). The IJRP included the following:	F 678	Identification Of Other Affected Residents On 07/12/2024, the Director of Nursing (DON) reviewed the 127 residents health records; based on the data collected using the Matrix System, 112 are full codes, and 15 are DNR's Systemic Changes The administrator enrolled the Director of Staff Development (DSD) in the Red Cross Basic Life Support (BLS) Instructor's Course to ensure that the Registered Nurses (RN), Licensed Vocational Nurses (LVNs), and Certified Nurse Assistants (CNAs) will undergo direct training from an in-house certified Basic Life Support (BLS) Instructor. The Director of Staff Development (DSD) will submit a report to the Director of Nursing (DON) of the list of nursing staff who completed the Cardiopulmonary Resuscitation (CPR) training weekly, including the new hire. The Director of Staff Development (DSD) will complete the course on 08/04/2024. Registry staff will be oriented to facilities CPR and emergency response protocol prior to their start of shift by the RN supervisor or designee. New hires will receive CPR and emergency response training as part of their onboarding/ new hire orientation given by the DSD or designee. The Director of Staff Development (DSD) or designee will conduct a random call for a "Code Blue Mock Drill".The Licensed nurses will continue to monitor the safety of the residents, supervise them during mealtime, and be available 24/7 to provide basic life support (BLS) in the event of a Code Blue emergency. Emergency responder must immediately assess the resident. In the event of choking a Heimlich Manuever must be delivered. In an episode of cardiac arrest, the staff will immediately assess the resident, if no pulse or breathing noted, one staff must stay with the resident while another staff will verify the code status of the resident.	Completion Date: 07/12/2024 Completion Date 08/04/2024 Start date 08/04/2024-ongoing Monthly x3 months and then quarterly thereafter

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F 678	Continued From page 3 a. On 07/16/2024, CNA 5 and Licensed Vocational Nurse (LVN 3) were in-serviced and counseled by the DON regarding immediate emergency response to a resident who was choking or found unresponsive. For choking, staff must initiate the Heimlich maneuver. For the unresponsive resident, staff will call the resident's name to establish responsiveness; if there is no response, facility staff will assess for breathing and pulse. Cardiopulmonary resuscitation (CPR) will be initiated if a resident is found with no breathing or pulse. b. On 07/12/2024,7/13/2024 and 7/17/2024, the DON and DSD provided an in-service regarding the emergency management of a resident chocking and cardiopulmonary arrest. c. On 07/16/2024, the DON coordinated with American Heart Association Accredited Basic Life Support (BLS) Instructor, an outside provider, to provide an in-service, education, and conduct a competency assessment, to the nursing staff. d. On 07/18/2024, the American Heart Association Basic Life Support Instructor will provide re-certification training to the listed nursing staff: One (1) Registered Nurse (RN), one (1) LVN, and two (2) CNAs will be attending the training. e. On 07/15/2024, the DSD conducted an audit on RNs, LVNs, and CNAs for the current Basic Life Support Certification. Based on the record review, one RN, one LVN, and two CNAs must be re-certified. The 4-nursing staff with a lapsed CPR card were removed from the daily schedule until completion of the CPR recertification.	F 678	once confirm that resident is full codestatus, if the sorrounding area is safe, a resident will not be transfer or remove from the location, immediately start the cardiopulmonary resuscitation (CPR) One staff must bring the emergency care (E-cart)/ supplies, onse staff must call 911. staff will continue to provide cardiopulmunary resuscitation (CPR) until the Emergency Medical Services (EMS) arrived THe Orector of Nursing (DON) will be immedialely notified Quality Assurance The Director of Staff Development (DSD) will submit the Code Blue Mock Drill Report to the Director of Nursing (DON) monthly. The Director of Nursing (DON) will submit the report to the Quality Assurance and Utilization Management Committee quarterly during the Continuous Quality Improvement (CQI).	Completion Date: 08/05/2024 Completion Date 08/05/2024

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F 678	Continued From page 4 f. The DON reviewed the 127 residents' health records, based on the data collected using the facility Matrix System, there are 112 residents that are Full codes, and 15 residents that a Do Not Resuscitate. ([DNR] a person has decided not to have CPR attempted on them if their heart or breathing stops) g. The ADM enrolled the DSD in the Red Cross Basic Life Support (BLS) Instructor's Course to ensure RNs, LVNs and CNAs will undergo direct training from an in-house certified Basic Life Support (BLS) instructor. The DSD will submit a report to the Director of Nursing (DON) of the list of nursing staff who completed the Cardiopulmonary Resuscitation (CPR) training weekly, including the new hire. The DSD will complete the course on 08/04/2024. h. The DSD or designee will conduct a monthly call for a "Code Blue Mock Drill." The licensed nurses will continue to monitor the safety of the residents, supervise them during mealtime, and be available 24/7 to provide basic life support (BLS) in the event of a Code Blue emergency. Emergency responder must immediately assess the resident. In the event of chocking a Heimlich maneuver must be delivered. In an episode of cardiac arrest, the staff will immediately assess the resident, if no pulse or breathing noted, one staff must stay with the resident while another staff will verify the code status of the resident, once confirm that resident has a full code status, if the surrounding area is safe, a resident will not be transfer or remove from the location, immediately start the cardiopulmonary resuscitation (CPR). One staff must bring the emergency cart (E-cart)/supplies, one staff must call for 911, staff will continue to provide	F 678		

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cardiopulmonary resuscitation until the Emergency Medical Services (EMS) arrived. The Director of Nursing (DON) will be immediately notified.

Quality Assurance:

The Director of Staff Development (DSD) will submit the Code Blue Mock Drill Report to the Director of Nursing (DON) monthly. The Director of Nursing (DON) will submit the report to the Quality Assurance and Utilization Management Committee quarterly during the Continuous Quality Improvement (CQI).

Findings:

During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on 09/19/2008 and re-admitted on 06/14/2020, with diagnoses including blindness, essential hypertension (high blood pressure), seizure disorder (a sudden, uncontrolled burst of electrical activity in the brain), and dementia (the loss of cognitive functioning -thinking, remembering, and reasoning) with psychosis (person is disconnected from reality).

During a review of Resident 1's Minimum Data Sheet ([MDS]- a standardized assessment and care screening tool) dated 05/31/2024 indicated Resident 1 had severely impaired cognitive skills (ability to learn, understand, and make decisions) for daily decision making and required supervision or touching assistance for eating, upper body dressing, partial or moderate assistance for oral hygiene, toileting, putting on and taking off footwear, maximal assistance for

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F 678	Continued From page 6 shower and lower body dressing. Resident 1 has severely impaired vision. The MDS indicated Resident 1 did not have Physician's Order for Life Sustaining treatment ([POLST] a written medical order from a physician that specify the types of medical treatment resident want to receive during serious illness).During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR) Communication Form dated 07/06/2024, SBAR indicated Resident 1 status was a Full Code. During a review of Resident 1's History and Physical (H&P), dated 9/09/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a concurrent interview and record review on 7/9/2024 at 3:37 p.m., with Registered Nurse (RN 2) Resident 1's Nursing Progress Notes dated 07/06/2024 were reviewed. The Nursing Progress Notes indicated Resident 1 died of cardiac arrest (heart stops beating suddenly) while he was having dinner in the dining room when suddenly became unresponsive, not breathing, and without pulse on 07/06/2024 at 5:27 p.m. RN 2 stated the Nursing Progress Notes indicated CPR was not initiated until Resident 1 was wheeled out from the dining room back f to Resident 1's room. During an interview on 07/10/2024 at 4:30 p.m., RN 2 stated he was not present in the dining room when Resident 1 became unresponsive , but staff informed him, and he came to the dining room to help. RN 2 stated if Resident 1 was a Full code the licensed nurses should have immediately start CPR as soon as Resident 1 become unresponsive and not breathing. RN 2	F 678		

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stated it was important to initiate CPR right away when Resident 1 became unresponsive, not breathing and without the pulse, because every second counts and time was a factor to save Resident 1's lives.

During viewing on 7/10/2024, at 9:35 a.m., of the facility's recorded video footage for 7/6/2024, and concurrent interview with the ADM, the video recording indicated that on 7/6/2024 at 5 p.m., Resident 1 was sitting on a wheelchair in the dining room waiting for his dinner to be served. The recorded video demonstrated that at 5:27 p.m., while Resident 1 was having dinner, CNA 5 was running toward Resident 1's direction. The recorded video demonstrated Resident 1, while on the wheelchair, slumped forward and was not moving. The video demonstrated CNA 5 picked Resident 1 up and performed the Heimlich maneuver. Resident 1 was remaining unresponsive. CNA 5 placed the resident back on a wheelchair and wheeled Resident 1 out of the dining room back to his room. At 5:35 p.m., crash cart was brought in Resident 1's room and at 5:43 p.m., paramedics arrived. The video recording indicated there was an eight-minutes delay from the time Resident 1 slumped forward and became unresponsive until staff initiated Resident 1's CPR

During an interview on 7/11/2024 at 9:07 a.m., CNA 5 stated he was responsible for taking care of Resident 1 while in the dining room on 7/6/2024. CNA 5 stated he thought Resident 1 was choking when Resident 1 became unresponsive during dinner. CNA 5 stated he performed a Heimlich maneuver but Resident 1 continue to be unresponsive. CNA 5 stated LVN 3 came and assessed Resident 1's airway. CNA 5

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F 678	Continued From page 8 stated LVN 3 said she cannot see any food blockage in Resident 1's mouth. CNA 5 stated Resident 1 continued to be unresponsive. CNA 5 stated she asked LVN 3 to perform CPR but was told "not yet." CNA 5 stated CPR was not provided to Resident 1 when Resident 1 remained unresponsive and LVN 3 confirmed the resident had no pulse. CNA 5 stated if Resident 1's CPR was started right away "we could have saved his life." CNA 5 added that LVN 3 did not call 911 at the time when Resident 1 became unresponsive and not breathing. CNA 5 stated LVN 3 instructed him to wheel Resident 1 out from the dining room back to Resident 1's room so that CPR can be provided. CNA 5 stated LVN 3 was concern for Resident 1's privacy and not to make other residents in the dining room panic. During an interview on 7/11/2024 at 12:18 p.m. LVN 2 stated LVN 3 came and help when Resident 1 was observed unresponsive. LVN 2 stated Resident 1 was grabbing his chest and then became unresponsive, so staff thought Resident 1 was choking. LVN 2 stated CNA 5 provided Heimlich maneuver while LVN 3 assessed the airway. LVN 2 stated CPR was not started in the dining room right away when Resident 1 became unresponsive and had no signs of pulse. LVN 2 stated that there was a delay in initiating CPR, and no one called 911 for emergency services. LVN 2 stated CPR was initiated when Resident 1 was back in his room and transferred back to bed. LVN 2 stated that CPR was not done on the floor in the dining room out of concern for the resident's privacy and to prevent other residents in the dining room to panic. During an interview on 7/12/2024 at 11:50 a.m.,	F 678		

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F 678	Continued From page 9 LVN 2 stated on 7/6/2024 at approximately 5:27 p.m., Resident 1 was sitting on his wheelchair in the dining room. LVN 2 stated Resident 1 lost consciousness when CNA 5 was doing the Heimlich maneuver. LVN 2 stated CNA 5 sat Resident 1 on his wheelchair, wheeled Resident 1 back to his room and carried Resident 1 to his bed. LVN 2 stated CPR was not initiated right away on the scene (dining room). LVN 2 stated that every second mattered to save Resident 1's live. LVN 2 stated if CPR was started right away when Resident 1 became unresponsive there could be a chance of the resident survival. During an interview on 7/12/2024 at 12:05 p.m., the DON stated CPR should not be delayed, once resident became unresponsive, not breathing and no pulse, staff should respond quick in an emergency and initiate CPR. During an interview on 7/12/2024 at 12:10 p.m. CNA 5 stated LVN 5 and LVN 3, who responded when Resident 1 became unresponsive, did not initiate CPR right away and did not call 911. During an interview on 7/12/2024 at 3:40 p.m., RN 1 stated that CPR should have been initiated right away when staff identified Resident 1 was unresponsive and not breathing. RN 1 stated CNA 5 and LVN 3 should not have taken Resident 1 to his room and place Resident 1 on bed before starting CPR, because time was very critical and important. The DON stated CNA 5 and LVN 3 should have initiated CPR as soon as Resident 1 was found unresponsive and possibly could have saved Resident 1's life. During a review of an online article titled, "American Heart Association 2020 CPR and Emergency Cardiovascular Care Committee	F 678		

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F 678	Continued From page 10 Guidelines," the article indicated, the adult basic life support algorithm (a process or set rules to be followed) for healthcare providers indicated to verify for scene safety, check for responsiveness, shout for nearby help, look for no breathing or only gasping and check pulse simultaneously (at the same time). The guidelines further indicated if there was no breathing, or only gasping, with no pulse, to immediately begin CPR and perform cycles of thirty chest compressions (the act of applying pressure to someone's chest to help blood flow) and two breaths. https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines During a review of the facility's P&P titled "Cardiopulmonary Resuscitation," (undated) the P&P indicated "Establish the need for CPR, send another person to call for emergency services, remain with the resident and call for help by following your facility policy for calling a code or getting emergency assistance."	F 678		