POC Accepted #2672 12/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the investigation of a Complaint Investigation during an Abbreviated Standard Survey. Complaint number: CA00597204 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 39672 The inspection was limited to the specific Complaint investigation and does not represent the findings of a full inspection of the facility. Two deficiencies were issued for Complaint CA00597204	F 000	This Plan of Correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.	
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	580	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO BE AFFECTED: RESIDENT I NO LONGER RESIDES AT THE FACILITY	11/16/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 11/2/18

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.

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy and notify the physician of a resident's change of condition which included the abnormal vital signs (clinical measurements, specifically pulse rate, temperature, respiration	F 580	IDENTIFICATION OF RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: DON and RN supervisors will assess residents having the potential to be affected by this deficiency by ensuring any resident at risk for C.O.C are properly assessed and care planned. MEASURES/SYSTEMATIC CHANGES TO ENSURE THE DEFICIENT PRACTICE DOES NOT REOCCUR: DON in serviced all licensed nurses on 10/25/18 on notifying the physician of resident's change of condition which include the abnormal vital signs (clinical measurements specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of essential body functions) and O2 saturation.	

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F 580	Continued From page 2 rate, and blood pressure, that indicate the state of essential body functions) and oxygen (O2) saturation ([percentage of O2 [sat]) level for one of three sampled residents (Resident 1). Resident 1 had a low blood pressure at 86/52 millimeter of mercury (mmHg) (normal reference range [NNR] = 120/80 mmHg) and a low O2 sat of 89 percent ([%] NRR= 95-100 %). This deficient practice resulted in a delay in diagnosis and treatment for Resident 1 who complained of nausea/vomiting with stomach pains and shortness of breath for two days. Resident 1 was transferred to the general acute care hospital (GACH), admitted into the hospital, transferred to intensive care unit (ICU), where Resident 1 went into cardiac arrest (a sudden stop in effective and normal blood circulation due to failure of the heart to pump blood), was intubated (the insertion of a breathing tube into the trachea), placed on a mechanical ventilator (artificial ventilation [breathing] used to assist or replace spontaneous breathing) and expired 3 days later. Findings: A review of a GACH's Adult Assessment, dated 6/20/18 at 8:03 a.m., prior to being admitted to the facility, Resident 1's systems were assessed to be WDL (within define limits) with negative laboratory results for cardiovascular, respiratory, gastrointestinal, genitourinary and the skin all with no abnormalities. Resident 1's chest x-ray report, dated 6/20/18 indicated there was no acute problems prior to the transfer to the facility.	F 580	MONITORING: Daily audits will be conducted for residents with C.O.C for the next 30 days by medical records director or designee to ensure that resident's MD are notified of any change of condition which include the abnormal vital signs. Significant finding will be submitted to the DON and will be forwarded to QA Committee for trending analysis recommendations and corrective actions Completion date November 16, 2018	

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F 580	Continued From page 3	F 580		

A review of Resident 1's Face Sheet (Admission Record) indicated the resident was admitted to the facility on 6/20/18. Resident 1's diagnoses included status-post fall with a right hip fracture (a break in a bone), right elbow fracture, hypertension (high blood pressure) and diabetes (high blood sugar).

A review of Resident 1's Minimum Data Set (MDS), a standardized assessment a care screening tool, dated 6/27/18, indicated Resident 1's Brief Interview for Mental Status ([BIMS] mental assessment test]) score was 13 (13-15=cognition intact [thought process]).

A review of Resident 1's Nursing Admission Screening/History, dated 6/20/18 and timed at 8:25 p.m., indicated Resident 1 was alert, had normal lung sounds, pulse rate was regular rhythm, bowel sounds present and abdomen soft and non-tender. Resident 1's vital signs, dated 6/20/18 at 9:10 p.m., were as follow:

Temperature 98.2 normal reference range ([NRR] =97.7-99.5 °F).
Pulse 78 (NRR 60-100 beats per minute)
Respiration 18 bpm ([breathes per minute] NRR= 12 to 20).
Blood Pressure 130/70 mmHg (NRR=120/80 mmHg)
O2 saturation 98% on room air (NRR 94-99%)

A review of a Nursing Progress Note, dated 7/24/18 and timed at 7:50 p.m. indicated Resident 1 was having episodes of vomiting (forceful expulsion of the contents of the stomach via the mouth or sometimes the nose), constipation (bowel movements that are infrequent or hard to pass) with abdominal discomfort. According to

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F 580	Continued From page 4 the note, the nurse called the physician and received an order at 8:10 p.m., on 7/24/18, for labs to be drawn, abdominal x-ray, medication for nausea/vomiting, and a laxative and fleet's enema for constipation. A Nursing Progress Note, dated 7/25/18 and timed at 9:39 a.m., indicated Resident 1 was complaining of nausea/vomiting and difficulty breathing with a low blood pressure of 86/52 and O2 sat of 89% on room air. The physician was called and Nurse Practitioner 1 (NP 1 [an Advanced Practice Registered Nurse who has additional responsibilities for administering patient care than RN's) called back and was informed of Resident 1's condition and ordered oxygen via nasal cannula ([N/C] plastic tube inserted into the nostrils to deliver oxygen) at 2-4 liters per minute for shortness of breath. A review of Resident 1's abdominal x-ray report, dated 7/25/18 and timed at 2:19 a.m., indicated the following: 1. Gastric distention (occurs when substances, such as air (gas) or fluid, accumulate in the abdomen causing its expansion) 2. Possibility of gastric outlet obstruction (a medical condition where there is an obstruction at the level of the pylorus, which is the outlet of the stomach) is not excluded 3. Follow-up examination was recommended. A review of Resident 1's Nursing Progress Note, dated 7/26/18 and timed at 8:55 a.m., indicated FM 1 was made aware of Resident 1's condition and FM 1 requested a transfer to the hospital. The progress note indicated NP 1 was notified and called back at 9:15 a.m., on 7/26/18 and	F 580		

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F 580	Continued From page 5 stated, "There was no need to transfer the resident right now." A review of Resident 1's Nursing Progress Note, dated 7/26/18 and timed at 11:40 a.m., the O2 saturation remained low at 87-90% with 2 liters of oxygen infusing via N/C with heavy breathing. A review of Resident 1's nursing progress note, dated 7/26/18 and timed at 11:52 a.m., indicated NP 1 called back with orders to transfer the resident to the GACH. Resident 1 was transferred by Basic Life Support ambulance at 2:25 p.m. (over two hours later) and not via 911 (immediate transfer) emergency. A review of a physician's telephone order, dated 7/26/18 and timed at 11:52 a.m., indicated to transfer the resident to the GACH due to persistent nausea and abnormal lab results. A review of the ambulance "Patient Care Report," dated 7/26/18 indicated a call was received for a basic transport at 12:09 p.m., on 7/26/18 and they arrived to the facility over two hours later, at 2:46 p.m. As documented, upon the BLS arrival, Resident 1 had rapid, labored breathing (an abnormal respiration characterized by evidence of increased effort to breathe) with an O2 saturation of 87%. The resident's primary complaint was documented as abdominal pain with nausea and vomiting for two days. On 8/7/18 at 2 p.m., during an interview, FM 1 stated Resident 1 was admitted to SNF for rehabilitation for the hip and elbow fracture, but while in the facility the resident was not given adequate care, which included not being bathed regularly, for which she had expressed her	F 580		

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F 580	Continued From page 6 concerns to the social worker, staff and NP. FM 1 stated Resident 1 also developed pressure sores on both heels in her short stay. On 8/16/18 at 4:15 p.m., during a telephone interview, the Registered Nurse Charge Nurse 1 (RN 1) stated he documented the resident' low blood of 85/52 and O2 Sat of 89% on the nursing progress notes on 7/25/18. RN 1 stated he also called the NP and was told the resident's condition would need to be reported to the charge nurse, but since he was the charge nurse, it was not reported further. On 9/5/18 at 12:55 p.m., during a telephone interview, NP 1 stated she received a call from the facility's nursing staff on 7/26/18 with abnormal lab values and an abdominal x-ray report for Resident 1. NP 1 stated she informed the nursing staff that she would discuss with the physician and together they would go to the facility to see the resident. NP 1 stated the nursing staff did not give her the information that the resident was in any distress or had a low blood pressure and had she known she would had transferred the resident sooner. On 9/6/18 at 12:30 p.m., during an in-person interview and chart review, NP 1 stated she was not aware of the family's request to transfer Resident 1 to the GACH and was not aware of the delay in transport to the GACH when orders were given to transfer. NP 1 stated she thought the nurses called 911, given the resident's condition. A review of the American Heart Association's (AHA) website, on 10/12/18, indicated "Unlike men, women's most common heart attack	F 580		

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F 580	Continued From page 7 symptoms were shortness of breath, nausea/vomiting. The AHA indicated calling 911 was almost always the fastest way to get lifesaving treatment." https://www.heart.org/en/health-topics/heart-failure/warning-signs-of-heart-failure A review of GACH emergency department (ED) record, dated 7/26/18 and timed at 3:18 p.m., indicated Resident 1 presented with shortness of breath, abdominal pain, N/V and ulcers to bilateral feet. Resident 1's Lab results were as follows: 1. Glucose level 175 (NRR=74-106) 2. Blood Urea Nitrogen ([BUN] indicator of kidney function) 89 (NRR=7-18) kidney function 3. Creatinine (indicator of kidney function) 42 (NRR=0.5-1.5) 4. Albumin (indicator of liver and kidney function, and malnutrition) 3.0 (NRR=3.8-5.2) 5. Brain natriuretic peptide ([BNP] indicator of heart function) 50089 (NRR=<450) elevation=congestive heart failure/heart attack 6. Troponin 20.300 (NRR=0.000-0.045) indicative of cardiac failure 7. White blood count (WBC)16.90 (NRR=3.50-10.60) 8. Hemoglobin (a protein inside red blood cells that carries oxygen from the lungs to tissues and organs in the body and carries carbon dioxide back to the lungs) 9.4 (NRR=12.0-16.00) 9. Liver enzymes; Aspartate aminotransferase (AST) 2076 (NRR=15-37) and Alanine aminotransderase (ALT) 3362 (NRR=12-78) The GACH ED record indicated Resident 1 was admitted to ICU with diagnoses of acute MI ([myocardial infarction] heart attack), CHF	F 580		

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F 580	Continued From page 8 (congestive heart failure), sepsis (a life-threatening condition that arises to the response of infection caused in injury to its own tissues and organs), pneumonia (inflammation of one or both lungs, with dense areas of lung inflammation), and urinary tract infection (infection of the kidney, ureter, bladder, or urethra). A review of GACH's Discharge Summary, dated 8/16/18 indicated Resident 1 was admitted to GACH on 7/28/18 and expired on 7/29/18, after a cardiac arrest (heart stoppage) and multi-organ failure. The resident was made a do not resuscitate ([DNR] withhold of cardiopulmonary resuscitation [CPR/ procedure to revive the heart and lungs] or advanced cardiac life support [ACLS]), and multi-organ failure. A review of Resident 1's Death Certificate indicated the date of death was 7/29/18 and the cause of death was listed as sepsis (life-threatening response to infection, which can lead to tissue damage, organ failure and death) and non-systemic elevation myocardial infarction (MI/heart attack). On 10/18/18 at 10:15 a.m., during a telephone interview, the DON stated if it was just a "normal" change in condition the nurse could call BLS, but in this case, the nurse should have called 911 and not even wait to call the physician. The DON stated they should have called him if they were not sure, especially since the resident was a new admit and they were not that familiar with the resident. The DON stated they did not have a policy regarding when to call BLS or 911, but stated when in doubt the nurse should have called 911.	F 580		

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F 580	Continued From page 9 A review of the facility's policy and procedure titled, "Acute Condition Changes-Clinical Protocol," indicated the staff would report any and all changes of a resident to the physician, which included vital signs, onset, duration and severity of changes, recent labs and pain level.	F 580		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all the necessary care and services were provided to a resident, which included sending the resident to the hospital after a change in condition via 911 emergency, and not basic life support ambulance, which took over two hours for one of three sampled residents (Resident 1). Resident 1, who had a change in condition for two days with a low blood pressure at 85/52 (normal reference range [NNR] = 120/80) and a low oxygen (O2) saturation of 89 percent (%) NRR= 95-100 %) and nausea and vomiting with stomach pain, needed a higher level of care, but was not sent to the general acute care hospital (GACH) timely for two days, and when sent, it was not by 911 (Immediate) emergency transport (crossed referenced to	F 684	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO BE AFFECTED: Resident #1 no longer resides in this facility. IDENTIFICATION OF RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: All resident have the potential to be affected by the practice.	11/16/18

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F 684	Continued From page 10 F680). This deficient practice resulted in a delay in diagnosis and treatment for Resident 1 who complained of nausea/vomiting with stomach pains and shortness of breath for two days. Resident 1 was transferred to the GACH, admitted into the hospital, transferred to intensive care unit (ICU), where Resident 1 went into cardiac arrest (a sudden stop in effective and normal blood circulation due to failure of the heart to pump blood), was intubated (the insertion of a breathing tube into the trachea [tube-like portion of the respiratory tract allowing for the passage of air]), placed on a mechanical ventilator (artificial ventilation [breathing] used to assist or replace spontaneous breathing) and expired 3 days later. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated the resident was admitted to the facility on 6/20/18. Resident 1's diagnoses included status-post fall with a right hip fracture (a break in a bone), right elbow fracture, hypertension (high blood pressure) and diabetes (high blood sugar). A review of Resident 1's Minimum Data Set (MDS), a standardized assessment a care screening tool, dated 6/27/18, indicated Resident 1's Brief Interview for Mental Status ([BIMS] mental assessment test]) score was 13 (13-15=cognition intact [thought process]). A review of Resident 1's Nursing Admission Screening/History, dated 6/20/18 and timed at	F 684	License Nurses have been in serviced on October 25, 2018 by the DON on conditions that may warrant transfer to the acute level of care via 911 ALS emergency response and those conditions that may be transferred using basic life support services. All conditions requiring transfer to the acute level will be clarified with the physician or designee giving the order for transfer to specifically address the type of transport necessary. MEASURES/SYSTEMATIC CHANGES TO ENSURE THE DEFICIENT PRACTICE DOES NOT REOCCUR: DON will monitor all change of condition and transfer to the hospital for 3 months to ensure that the license nurses are using the correct type of Ambulance service. Significant findings will be forwarded to the QA committee for trending analysis, recommendations and corrective actions. Completion date November 16, 2018	

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F 684	Continued From page 11 8:25 p.m., indicated Resident 1 was alert, had normal lung sounds, pulse rate was regular rhythm, bowel sounds present and abdomen soft and non-tender. Resident 1's vital signs were all within normal limits (WNL). A review of a physician's order, dated 6/28/18 indicated for one liter (1000 ml [milliliter]) of IV (intravenous [into veins]) .5 normal saline (NS) at 80 ml an hour. On 6/29/18, another .5 NS two liters at 70 ml/hour (2000 ml). On 7/2/18, the physician ordered another liter (1000 ml) of .5 NS via IV at 70 ml an hour. A total of 4 liters NS was given via IV for dehydration (too much water lost, not enough water taken in). A review of a physician's progress note, 15 days after admission to the facility, dated 7/5/18 and timed at 1:40 p.m., indicated Resident 1's family member (FM 1) was not happy with the resident's care and requested a transfer to another SNF (skilled nursing facility). A review of a Nursing Progress Note, dated 7/5/18 and timed at 4:25 p.m., and signed by the facility's social worker indicated FM 1 would email concerns/grievances to her. A review of a Social Worker Note titled, "Resident Grievance/Complaint Form," dated 7/9/18, indicated an attached letter from FM 1 in regards to concerns about Resident 1's care or lack thereof and dietary issues. A review of a Nursing Progress Note, dated 7/24/18 and timed at 7:50 p.m., indicated Resident 1 was having episodes of vomiting (forceful expulsion of the contents of the stomach via the mouth or sometimes the nose),	F 684		

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	555128	A. BUILDING _____ B. WING _____	C 10/24/2018

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F 684	Continued From page 12 constipation (bowel movements that are infrequent or hard to pass) with abdominal discomfort. According to the note, the nurse called the physician and received an order at 8:10 p.m., on 7/24/18, for labs to be drawn, abdominal x-ray, medication for nausea/vomiting, and a laxative and fleet's enema for constipation. A Nursing Progress Note, dated 7/25/18 and timed at 9:39 a.m., indicated Resident 1 was complaining of nausea/vomiting and difficulty breathing with a low blood pressure of 85/52 and O2 sat of 89% on room air. The physician was called and Nurse Practitioner 1 (NP 1 [an Advanced Practice Registered Nurse who has additional responsibilities for administering patient care than RN's) called back and was informed of Resident 1's condition and ordered oxygen via nasal cannula ([N/C] plastic tube inserted into the nostrils to deliver oxygen) at 2-4 liters per minute for shortness of breath. A review of Resident 1's abdominal x-ray report, dated 7/25/18 and timed at 2:19 a.m., indicated the following: 1. Gastric distention (occurs when substances, such as air (gas) or fluid, accumulate in the abdomen causing its expansion) 2. Possibility of gastric outlet obstruction (a medical condition where there is an obstruction at the level of the pylorus, which is the outlet of the stomach) is not excluded 3. Follow-up examination was recommended. A review of a nursing progress note, dated 7/26/18 and timed at 8:55 a.m., indicated FM 1 was made aware of Resident 1's condition and FM 1 requested a transfer to the hospital. NP 1	F 684		

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F 684	Continued From page 13 was notified and called back at 9:15 a.m., on 7/26/18 and stated, "There was no need to transfer the resident right now." A review of a Nursing Progress Note, dated 7/26/18 and timed at 11:40 a.m., the O2 saturation remained low at 87-90% with 2 liters of oxygen infusing via N/C with heavy breathing. A review of Resident 1's nursing progress note, dated 7/26/18 and timed at 11:52 a.m., indicated NP 1 called back with orders to transfer the resident to the GACH. Resident 1 was transferred by Basic Life Support ambulance (transport for patients who do not require extra support or cardiac monitoring) at 2:25 p.m. (over two hours later) and not via 911 emergency. A review of a physician's telephone order, dated 7/26/18 and timed at 11:52 a.m., indicated to transfer the resident to the GACH due to persistent nausea and abnormal lab results. A review of the ambulance "Patient Care Report," dated 7/26/18, indicated a call was received for a basic transport at 12:09 p.m., on 7/26/18 and they arrived to the facility over two hours later, at 2:46 p.m. As documented; upon the BLS arrival, Resident 1 had rapid, labored breathing (an abnormal respiration characterized by evidence of increased effort to breathe) with an O2 saturation of 87%. The resident's primary complaint was documented as abdominal pain with nausea and vomiting for two days. On 8/7/18 at 2 p.m., during an interview, FM 1 stated Resident 1 was admitted to SNF for rehabilitation for the hip and elbow fracture, but while in the facility the resident was not given	F 684		

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F 684	Continued From page 14	F 684		

adequate care, which included not being bathed regularly, for which she had expressed her concerns to the social worker, staff and NP. FM 1 stated Resident 1 also developed pressure sores on both heels in her short stay.

On 8/16/18 at 4:15 p.m., during a telephone interview, Registered Nurse Charge Nurse 1 (RN 1) stated he documented the resident' low blood of 85/52 and O2 Sat of 89% on the nursing progress notes on 7/25/18. RN 1 stated he also called the NP and was told the resident's condition would need to be reported to the charge nurse, but since he was the charge nurse, he did not report it further.

On 9/5/18 at 12:55 p.m., during a telephone interview, NP 1 stated she received a call from the facility's nursing staff on 7/26/18 with abnormal lab values and an abdominal x-ray report for Resident 1. NP 1 stated she informed the nursing staff that she would discuss with the physician and together they would go to the facility to see the resident. NP 1 stated the nursing staff did not give her the information that the resident was in any distress or had a low blood pressure and had she known she would had transferred the resident sooner.

At 12:30 p.m., on 9/6/18 at 12:30 p.m., during an in-person interview and chart review, NP 1 stated she was not aware of the family's request to transfer Resident 1 to the GACH and was not aware of the delay in transport to the GACH when orders were given to transfer. NP 1 stated she thought the nurses called 911, given the resident's condition.

A review of the American Heart Association's

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F 684	Continued From page 15 (AHA) website, on 10/12/18, indicated "Unlike men, women's most common heart attack symptoms were shortness of breath, nausea/vomiting. The AHA indicated calling 911 was almost always the fastest way to get lifesaving treatment." https://www.heart.org/en/health-topics/heart-failure/warning-signs-of-heart-failure A review of GACH emergency department (ED) record, dated 7/26/18 and timed at 3:18 p.m., indicated Resident 1 presented with shortness of breath, abdominal pain, N/V and ulcers to bilateral feet. Resident 1's Lab results were as follows: 1. Glucose level 175 (NRR=74-106) 2. Blood Urea Nitrogen ([BUN] indicator of kidney function) 89 (NRR=7-18) kidney function 3. Creatinine (indicator of kidney function) 42 (NRR=0.5-1.5) 4. Albumin (indicator of liver and kidney function, and malnutrition) 3.0 (NRR=3.8-5.2) 5. Brain natriuretic peptide ([BNP] indicator of heart function) 50089 (NRR=<450) elevation=congestive heart failure/heart attack 6. Troponin 20.300 (NRR=0.000-0.045) indicative of cardiac failure 7. White blood count (WBC)16.90 (NRR=3.50-10.60) 8. Hemoglobin (a protein inside red blood cells that carries oxygen from the lungs to tissues and organs in the body and carries carbon dioxide back to the lungs) 9.4 (NRR=12.0-16.00) 9. Liver enzymes; Aspartate aminotransferase (AST) 2076 (NRR=15-37) and Alanine aminotransderase (ALT) 3362 (NRR=12-78)	F 684		

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F 684	Continued From page 16 The GACH ED record indicated Resident 1 was admitted to ICU with diagnoses of acute MI (myocardial infarction [heart attack]), CHF (congestive heart failure), sepsis (a life-threatening condition that arises to the response of infection caused in injury to its own tissues and organs), pneumonia (inflammation of one or both lungs, with dense areas of lung inflammation), and urinary tract infection (infection of the kidney, ureter, bladder, or urethra). A review of GACH's Discharge Summary, dated 8/16/18 indicated Resident 1 was admitted to GACH on 7/26/18 and expired three days later, on 7/29/18, after a cardiac arrest (heart stoppage) and multi-organ failure. The resident was made a do not resuscitate ([DNR] withhold of cardiopulmonary resuscitation [CPR/ procedure to revive the heart and lungs] or advanced cardiac life support [ACLS]), and multi-organ failure. A review of Resident 1's Death Certificate indicated the date of death was 7/29/18 and the cause of death was listed as sepsis (life-threatening response to infection, which can lead to tissue damage, organ failure and death) and non-systemic elevation myocardial infarction ([MI] heart attack). On 9/6/18 at 3 p.m., during a telephone interview, NP 1 stated she had received complaints from Resident 1's family about care concerns and she had discussed the resident's "substandard care" with the Director of Nurses (DON). On 10/18/18 at 10:15 a.m., during a telephone interview, the DON stated if it was just a "normal"	F 684		

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F 684	Continued From page 17 change in condition the nurse could call BLS, but in this case, the nurse should have called 911 and not even wait to call the physician. The DON stated they should have called him if they were not sure, especially since the resident was a new admit and they were not that familiar with the resident. The DON stated they did not have a policy regarding when to call BLS or 911, but stated when in doubt the nurse should have called 911. A review of the facility's policy and procedure titled, "Acute Condition Changes-Clinical Protocol," revised 12/15, indicated the staff would report any and all changes of a resident to the physician, which included vital signs, onset, duration and severity of changes, recent labs and pain level.	F 684		