STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055862	A. BUILDING _____ B. WING _____	**04/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE GARDEN HEALTHCARE CENTER	**1899 N RAYMOND AVE PASADENA, CA 91103**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician immediately of the declining change in condition for one of two sampled residents (Resident 1). The Nurse Practitioner (NP), who was providing medical care on behalf of Resident 1's physician, placed Resident 1 on 10 liters per minute (LPM, the rate and amount at which [MED]gen flows) of [MED]gen via non-rebreather mask (NRBM, a device used to help in the delivery of [MED]gen) after a Licensed Vocational Nurse 1 (LVN 1) reported Resident 1's [MED]gen saturation (a measurement of [MED]gen level in the blood (normal levels between 95% to 100%)) was 78% on [DATE] at 8:15 PM. At 8:30 PM and 8:45 PM on the same day, LVN 1 observed the Resident 1 removing the NRBM. LVN 1 did not update the NP of the resident's current condition and response to the 10 LPM of [MED]gen via NRBM for two hours and 15 minutes. She updated the NP after the paramedics were called and CPR (CPR, an emergency procedure that combines chest compression with artificial ventilation (exchange of air between the lungs and the atmosphere) to restore blood circulation and breathing) had been started. This deficient practice resulted in Resident 1, who was having respiratory distress, was found unresponsive and requiring CPR without the Resident's physician being notified of changes in condition, and 911 not being called earlier. The resident died in the facility on [DATE]. Findings: A review of Resident 1's Face Sheet (admission record) indicated the facility admitted the resident on [DATE] and readmitted his on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and screening tool) dated [DATE], indicated the resident had severely impaired cognition (ability to think, understand, and reason). The MDS indicated Resident 1 needed extensive assistance (unable to complete independently, requiring help from facility staff to complete) for activities of daily living (ADLs), such as bed mobility, transferring, walking, dressing, and personal hygiene. A review of Resident 1's Nurse Practitioner's evaluation from a General Acute Care Hospital 1 (GACH 1) dated [DATE], indicated Resident 1 had increased congestion, wheezing, and a new condition of [MEDICAL CONDITION] ([MEDICAL CONDITION], the heart is unable to pump enough blood to the body to meet its [MED]genation needs and symptoms include shortness of breath). A review of Resident 1's GACH Discharge Instructions dated [DATE], indicated Resident 1 was discharged from the acute hospital with shortness of breath, cough, and acute (sudden) upper respiratory infection (infection that involves the nose and throat). A review of Resident 1's Progress Notes, dated [DATE], indicated the following: a. At 8:15 PM, Resident 1 complained of shortness of breath to LVN 1. Resident 1's vital signs indicated an [MED]gen saturation level of 78% on room air, blood pressure (BP) ,[DATE] millimeters of mercury (mm/Hg, normal BP is ,[DATE] mm/Hg) and respiratory rate (rate of breathing) of 20 breaths per minute (normal rate is 12 to 20 at rest). The record indicated no assessment of lung sounds. LVN 1 notified the NP and the NP ordered to administer Resident 1 [MED]gen at 10 LPM via NRBM until the resident was stable for transfer to the GACH 2. LVN 1 documented that NP would arrange Resident 1's transportation to GACH 2. Resident 1's [MED]gen saturation level went up to 95% after receiving 10 LPM of [MED]gen via NRBM. b. At 8:30 PM and 8:45 PM, LVN 1 observed Resident 1 removing the NRBM. c. At 9 PM, Resident 1's vital signs indicated a BP of ,[DATE] mm/Hg, RR of 20, pulse oximetry of 95% at 10 LPM. A late entry documentation entered on [DATE] at 9:08 PM, indicated Resident 1's BP was ,[DATE] and [MED]gen saturation of 87% on 10 LPM on [DATE] at 9 PM. The record indicated no assessment of lung sounds. d. At 9:15 PM, LVN 1 observed Resident 1 trying to remove the NRBM. Resident 1's [MED]gen saturation level was 95%. e. A late entry documentation entered on [DATE] at 9:08 PM, indicated Resident 1's BP was ,[DATE], heart rate (HR, the speed of the heart beat) of 92 beats per minute (normal range for HR is 60 to 100 beats per minute of BPM), RR of 18, with [MED]gen saturation level at 95% at 10 LPM of [MED]gen on [DATE] at 9:30 PM. The record indicates no assessment of lung sounds. f. At 9:37 PM, LVN 1 observed Resident 1 had removed the NRBM and the resident had an [MED]gen saturation level of 87%. LVN 1 received a call from the ambulance company notifying LVN 1 that the ambulance would be arriving in 90 minutes (to transport Resident 1 to GACH 2). g. At 10 PM, LVN 1 observed Resident 1 with the NRB mask on and an [MED]gen saturation level of 95%. A late entry documentation entered on [DATE] at 9:08 PM indicated Resident 1's BP was ,[DATE] mm/Hg, HR of 87, RR of 20 and [MED]gen saturation level of 95% on [DATE] at 10 PM. The record indicates no assessment of lung sounds. h. At 10:17 PM, LVN 1 observed Resident 1 pale and having troubled breathing. LVN 1 called a code STAT (an emergency call to staff that a resident is in cardiopulmonary (heart and lungs) arrest (to stop)). Registered Nurse (RN) 1 and Respiratory Therapist (RT) 1 entered Resident 1's room and started CPR. LVN 1 called for emergency services via 911 telephone number. The progress notes indicated the paramedics (persons trained to give emergency care) arrived and the paramedic continued CPR that lasted for 30 minutes. i. At 10:30 PM, LVN 1 paged the NP and notified the NP that she (LVN 1) called the 911 emergency telephone number (for emergency assistance and transport to a higher level of care than the facility could provide). j. At 10:50 PM, the paramedics spoke to Physician 2 and called Resident 1's time of death at 10:50 PM. During an interview, on [DATE] at 2:54 PM, LVN 1 stated she called and notified the NP of Resident 1's shortness of breath (on [DATE] at 8:15 PM). LVN 1 stated the NP ordered to give Resident 1 [MED]gen at 10 LPM via NRBM. LVN 1 stated the NP instructed her to wait for the NP to arrange Resident 1's transfer to GACH 2. LVN 1 stated she verbally directed Resident 1 to leave the NRBM on and the resident would respond by nodding his head and stated Ok. LVN 1 stated she did not implement other interventions aside from verbal directions. LVN 1 stated she had to document late entries (on [DATE]) in Resident 1's medical records because she checked the resident's vital signs more often than what she documented in the medical records (on [DATE]). LVN 1 stated she did not notify the NP that Resident 1 was removing the NRBM repeatedly and that his [MED]gen saturation level kept dropping. During a telephone interview, on [DATE] at 1:30 PM, the NP stated she ordered 10 LPM of [MED]gen for Resident 1 and she informed LVN 1 that she (the NP) would arrange for Resident 1's transportation to GACH 2. The NP stated LVN 1 notified her that Resident 1 was stable and the resident's [MED]gen saturation level went up to 96%. The NP stated the facility did not inform her of Resident 1's multiple attempts to remove the NRBM and the drops in the resident's [MED]gen saturation levels. The NP stated that emergency transport via 911 emergency call was not called to transfer Resident 1 immediately (to the hospital for a higher level of care) because the facility did not update her of Resident 1's condition. The NP stated the next telephone call she received from the facility was after Resident 1 expired (died). The NP stated the facility should have updated her of Resident 1's condition. During another telephone interview, on [DATE] at 12:15 PM, the NP stated she worked with Resident 1's attending physician (Physician 1). The NP stated she shared the on call duty responsibility in the facility with Physician 1. The NP stated if she had been notified of the drops in Resident 1's [MED]gen saturation levels while the resident was receiving 10 LPM of [MED]gen and the resident's several attempts to remove the NRBM, the NP would have instructed the facility to have someone stay one-on-one (one staff monitoring one resident) with Resident 1 and to call for emergency transportation services via 911 call. During an interview, on [DATE] at 10:02 AM, the Director of Nursing Designee (DOND) stated that LVNs should report to the DOND if they were not confident in providing care to residents with changes in condition. The DOND stated

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

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 0580 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) that a shortness of breath is a significant change in the resident's condition. The DOND stated, .most importantly, shortness of breath. The DOND stated the facility would usually call the NP because the NP was on call for Physician 1. The DOND stated it is the role of the NP to inform Physician 1 of the changes or updates for Resident 1. During a telephone interview, on [DATE] at 11:20 AM, the NP stated she should have been notified of the Resident 1's change of condition during the first desaturation (which occurred on [DATE] at 9 PM and [MED]gen saturation dropped to 87%) and Resident 1's attempts to remove the NRBM. The NP stated that Resident 1's frequent attempts to remove the NRBM indicated the intervention was not effective and the resident could be manifesting agitation and irritability from lack of [MED]gen. The NP stated that emergency transportation via 911 telephone number should be called for this situation. During an interview, on [DATE] at 3:18 PM, LVN 1 stated she called for emergency transportation via 911 telephone number while RN 1 and RT 1 initiated CPR to Resident 1. LVN 1 stated she did not call the DOND or RN 1 when Resident 1 did not respond to the NRBM intervention. A review of the facility's policy and procedure titled, Acute Condition Changes - Clinical Protocol, revised date ,[DATE], indicated, The staff will monitor and document the resident's progress and responses to treatment, and the Physician will adjust the treatment accordingly. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, revised dated ,[DATE] , indicated the, Nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident physical/emotional/mental condition or with the refusal of treatment.