STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056042	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA BAY VISTA HCC	5901 DOWNEY AVE LONG BEACH, CA 90805

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0678 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's nursing staff failed to initiate cardio-pulmonary resuscitation ((CPR) an emergency lifesaving procedure done when breathing or the heart stops) for one of three sampled residents (Resident 1). Resident 1 was found unresponsive with low oxygen saturation (percentage of oxygen in the blood) at 30 percent ((%) normal oxygen level is ,[DATE]% (below 90% is a low level of oxygen saturation)) and no blood pressure (force of blood pushing against the walls of your arteries each time your heart beats, it pumps blood into the arteries). This deficient practice resulted in a delay of appropriate medical interventions for Resident 1, who was found unresponsive with unstable vital signs (important medical measurements that indicate the status of the body's vital functions). Resident 1 was pronounced deceased in the facility on [DATE]. Findings: A review of Resident 1's Admission Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A stroke occurs when blood flow to a part of the brain is blocked). A review of Resident 1's quarterly Minimum Data Set (MDS), a resident assessment and care screening tool, dated [DATE], indicated Resident 1 had cognitive (thought process) problems, impaired decision-making, but was able to make needs known and usually able to understand others. According to the MDS, the resident was assessed as requiring a two-person physical assistance with bed mobility, transferring, and was totally dependent with locomotion on and off the unit and personal hygiene. A review of Resident 1's physician orders, dated [DATE] indicated for the resident to receive continuous oxygen at two (2) liters per minute (L/min) via nasal cannula (a flexible plastic tube used to deliver oxygen) to keep oxygen saturation (percentage of oxygen in the blood) at or above 94 % (percent) for [MEDICAL CONDITION]. The physician's orders [REDACTED]. Resident 1's baseline care plan summary was signed by several staff members including the former Director of Nursing (DON) and the Social Services Director (SSD). A review of Resident 1's untimed Licensed personnel weekly progress note written by Licensed Vocational Nurse 1 (LVN 1), dated [DATE] indicated At approximately 5:30 a.m., resident (Resident 1) was found in bed unresponsive, unable to record blood pressure and oxygen saturation measured at 30 %. Called 911 emergency services at approximately 5:40 a.m. (sic). Paramedics arrived at around 5:50 a.m. (sic) and examined resident (Resident 1) and pronounced resident dead on arrival. A review of Resident's 1 untimed licensed personnel weekly progress note written by LVN 1, dated [DATE] indicated Late entry - At 11 p.m., made rounds seen resident in bed asleep, but arousable (to stir to action or strong response); vital signs ,[DATE] (normal reference range (NRR) ,[DATE] -,[DATE] millimeter of mercury (mm Hg) unit of measurement), Pulse rate 82 (NRR ,[DATE]), body temperature 97.8 degrees Fahrenheit (NRR 97XXX,[DATE].8), Respirations 18 (NRR ,[DATE] breaths per minute (bpm)). Skin warm and dry to touch in no respiratory distress. At approximately 3 a.m., [DATE] the resident (Resident 1) was cleaned and brief changed by CNA (unknown certified nursing assistant). At approximately 5:30 a.m., on [DATE], while passing medication, the resident (Resident 1) was found to be unresponsive. Blood sugar checked and was 200 milligrams per deciliter (mg/dL (unit of measurement)) (NRR= ,[DATE] mg/dL) oxygen saturation at 30 %, respirations 12, pulse 100. Unable to record obtain blood pressure. Called 911 at approximately 5:40 a.m., paramedics arrived at 5:50 a.m. (sic). Resident (Resident 1) started breathing (sic). The documentation indicated the paramedics started CPR (sic) at approximately 6:10 a.m. and the resident was pronounced deceased by paramedics. A review of the Paramedics Incident Report, dated [DATE] and timed at 5:53 a.m., indicated: called received at 5:53 a.m., dispatched for Full Arrest (([MEDICAL CONDITION]) a sudden loss of blood flow resulting from the failure of the heart to pump effectively). Arrival to scene at 6:02 a.m. Patient (Resident 1) found lying in bed in supine position (flat on back) at nursing home with no pulse or respirations. Staff stated the resident last known well at 2:30 a.m. Patient in rigor mortis (stiffening of the joints and muscles of a body usually a few hours after death), pupils fixed (completely unresponsive to light) and unresponsive, negative response to painful stimuli, negative palpable pulse and apical pulse (audible heart beats; by placing a stethoscope (medical instrument) over the heart and counting for one minute). Provisional impression patient (Resident 1) dead. According to the Paramedics Incident report, Resident 1 was dead upon their arrival, apneic (not breathing) and skin was cold. The Paramedics Incident report indicated the reason for withholding CPR resuscitation was due to the resident having rigor mortis. The paramedics documented Resident 1's death was determined, and the paramedics left Resident 1's body at the facility. A review of Resident 1's certificate of death indicated Resident 1's date of death was on [DATE] at 5:30 (before arrival of the paramedics) indicated the immediate cause of death was listed as acute Cardiopulmonary Arrest ([MEDICAL CONDITION]). On [DATE] at 5:52 a.m., during a telephone interview, LVN 1 stated he was Resident 1's assigned nurse on [DATE] (11 p.m. to 7 a.m. shift) to the morning of [DATE]. LVN 1 stated during his shift rounds at an unknown time, he saw Resident 1 asleep in bed before he took his break at unspecified time. According to LVN 1, he did not see the resident at any other time during the shift until he started to pass the morning medication at 5:30 a.m. ([DATE]) and discovered Resident 1 was unresponsive and decided to check Resident 1's blood sugar. LVN 1 stated Resident 1 was breathing with respirations of 12 and a heart rate of 100 beats per minute. LVN 1 stated he attempted to take Resident 1's blood pressure and was unsuccessful. LVN 1 stated he did not remember if he provided Resident 1 with oxygen (physician's orders [REDACTED]. LVN 1 stated he raised Resident 1's head of bed up and left Resident 1 to call 911 and did not initiate CPR on Resident 1. LVN 1 stated, The paramedics initiated CPR on Resident 1 (sic). On [DATE] at 11:27 a.m., during a telephone interview, Resident 1's physician (Physician 1), who was the facility's medical director, in the presence of the Administrator (ADM) and the current DON, Physician 1 stated Resident's 1 documented vital signs were an indication the resident was unstable. Physician 1 stated he was not notified of the resident's change in condition. Physician 1 stated rigor mortis sets in when a person was deceased for more than ten (10) minutes, and the brain was deprived of oxygen more than six (6) minutes. Physician 1 stated, If a person's pupils are fixed and dilated it indicated the vital signs are completely gone. Physician 1 stated the nurse should have started CPR immediately and called 911 (emergency services) and notified him of the resident's change in condition. On [DATE] at 4:06 p.m., during a telephone interview, Resident 1's former roommate, Resident 2, stated the last time he saw Resident 1 alive was on [DATE] in the late afternoon. Resident 2 stated a staff member came in for a physical therapy session with Resident 1, who was slow to respond. Resident 2 stated later a staff member brought Resident 1's dinner on the evening of [DATE] and the meal was left uneaten and was never touched. According to Resident 2, from approximately 9 p.m. on [DATE] until the early morning hours of the next morning [DATE], Resident 1 was lying in bed and did not make any sounds. Resident 2 stated he did not see a staff member come in all night to clean or check on Resident 1, until he was found unresponsive. Resident 2 stated he was lying in the same room next to Resident 1 and the facility's staff did not come in to check on Resident 1 or take Resident 1's vital signs. A review of Resident 2's Admission Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. A review of Resident 2's MDS, dated [DATE] indicated Resident 2 had no cognitive (thought process) problems and/or impaired decision-making, and was able to make needs known and understand

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

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F 0678 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) others. A review of the facility's policy and procedure (P/P) titled, Cardiopulmonary Resuscitation last revised on [DATE] indicated cardiopulmonary resuscitation (CPR) is instituted in cases of recognized cardiac and/or [MEDICAL CONDITION] arrest until medical emergency personnel are available to take over the resuscitation efforts. Cardiopulmonary resuscitation is instituted on all residents except those designated as No Code or No CPR (to allow natural death). A review of the facility's P/P titled, Medical Emergencies- Code Blue (indicates medical emergency such as cardiac or respiratory arrest) last revised [DATE] indicated to ensure the prompt and effective response by the facility personnel during medical emergencies through the use of the code blue procedure. According to the P/P the facility will provide an appropriate level of response to the resident during medical emergencies. A medical emergency is defined as any of the following conditions requiring immediate medical intervention and the initiation of the code blue procedure: respiratory or [MEDICAL CONDITION]. The first of the facility personnel to arrive and find a resident with any of the above conditions will identify whether there is a cardiopulmonary or respiratory arrest by shaking the person and calling out their name a minimum of three times. The P/P indicated to respond to the resident immediately and send available staff to call a code blue. Commence one person CPR, according to current practice. If alone, do resuscitation for one minute before leaving the resident to call for help.