DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0065	A. BUILDING: _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PLACE	**1140 K AVENUE NW CEDAR RAPIDS, IA 52405**

(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) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 8 Number of tenants with cognitive impairment: 7 Total census: 15 Complaint #122515-C was investigated and the following regulatory insufficiencies were cited:	A 000	See attached POC 7/9/25	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policy and procedure related to medical emergencies and summoning help. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 8/7/24 Tenant C1's file revealed Interdisciplinary Notes indicated the following: -On 7/29/24 staff reported Tenant C1 complained of shortness of breath (SOB) with exertion in the last 24 hours. There was rubbing noted in both lungs and 2+ edema was noted in his bilateral lower extremities. Tenant C1 did not have a	A 150		

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cough or fever. The primary care provider (PCP) was notified.

-On 7/29/24 new orders were received for a complete blood count (CBD) with differential, brain natriuretic peptide (BNP), basic metabolic panel (BMP) and chest x-rays.

-On 7/29/24 the PCP examined him and the lab results returned and were faxed to the PCP.

-On 7/29/24 the x-ray returned and the results were sent to the PCP. The x-ray indicated congestive heart failure (CHF). New orders were received for Lasix 20 milligram (mg), daily weights report if his weight was up three pounds per day and repeat the BMP on 8/1/24. Orders were also received to take his blood pressure twice daily and report to the PCP if lower than 100/70. The PCP talked to the legal representative, discussed new orders and a possible change to the resuscitation status. He was currently a full code.

-On 7/29/24 the results of Tenant C1's BMP were 16433 and the PCP spoke with Tenant C1's legal representative and gave the choice of hospice or hospitalization. The legal representative chose to take Tenant C1 to the hospital.

-On 7/30/24 it was noted Tenant C1 returned from the hospital the previous evening. His lungs continued to have rubbing sounds in both sides. A report was given to the PCP.

-On 7/30/24 changes were made to Tenant C1's Iowa Physician Orders for Scope of Treatment (IPOST) and he was Do Not Resuscitate (DNR) with limited interventions.

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-On 7/31/24 it was noted Tenant C1 felt nauseous and Zofran was administered. His lung sounds were somewhat improved that morning, there was SOB with wheezing noted with exertion.

-On 8/1/24 Tenant C1 was very tired and was seen by the PCP. A blood draw was completed for labs and the results were faxed to the PCP. A new order was received for midodrine 2.5 mg, by mouth at morning and noon. An order to repeat the BMP on 8/5/24 was also received.

-On 8/2/24 staff reported Tenant C1 had passed. The PCP was notified.

A Vital Stats document indicated on 8/1/24 at 6:45 a.m. Staff A entered his pulse was 96 and his blood pressure was 88/63 when seated. The Vital Stats document indicated Tenant C1's blood pressure was taken and was outside of parameters in timeframe of 7/30/24 to 8/1/24.

A Physician's Telephone Order indicated on 8/1/24 and order was received for midodrine 2.5 mg, by mouth in the a.m. and at noon, in addition to taking his blood pressure twice daily while he was laying down. It was ordered to notify the PCP of blood pressure readings if below 100/70 or above 150/90. A Physician's Telephone Order indicated on 8/1/24 to hold Lasix 20 mg due to low blood pressure today. A fax to the PCP dated 8/1/24 indicated a telephone order read back indicated to hold Lasix on 8/2/24 in the a.m.

2. Continued record review of Tenant C1's file revealed no incident report, staff communication report, or additional documentation related to his sudden death completed by the Program. A Patient Care Record from the fire department who responded was obtained. The report

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indicated on 8/2/24 at 7:40 a.m. they were dispatched to the Program for a cardiac arrest, when on the way an update was provided indicating, per Program staff, the tenant was not able to be helped. When arrived they were taken to the apartment by staff, the apartment door was locked. There was no staff present and the bedroom door was closed. The door was opened and Tenant C1 was lying on right side in bed. He was cool to the touch, had mottled skin and was deceased. The report indicated the staff that was still in the room said "I checked on him at 6, he was very short of breath, so I took this blood pressure." The staff also said at 6:30 a.m. she called another staff to verify it due to issues with the blood pressure cuff. At that time his blood pressure was 88/63 and she reported he was "really struggling to breathe." Staff then called the nurse and were told to get him up, weigh him and to hold his water pill. When staff went back at 6:48 a.m. he had died. Staff reported he was a full code. The hospital was called for a time of death which was 7:53 a.m. It was noted on the report that Tenant C1 died at 6:48 a.m. and emergency medical services (EMS) were called at 7:40 a.m.

The report also indicated per dispatch and CNAs (staff) on scene the following timeline was provided:
- 6:00 a.m. Tenant C1 struggled to breathe and vitals were obtained
- 6:30 a.m. Another staff confirmed vitals were obtained and the nurse was notified. The nurse advised to weigh him and hold his water pill
- 6:48 a.m. Tenant C1 was found deceased
- 7:40 a.m. EMS was called
- 7:45 a.m. EMS arrived on scene
- 7:53 a.m. Doctor provided time of death

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A 150	Continued From page 4 Although the staff who stated she checked on him at 6:00 a.m. in the Patient Care Report was not identified by name, per interview with Staff A she was the staff assigned to his area that day and she gave him his medications, weighed him, and initially took his blood pressure. She went to get Staff B when the blood pressure cuff was not working. It should also be noted Staff A signed off the administration of his morning medications and weight for 8/2/24 on the August 2024 medication administration record (MAR). 3. When interviewed on 8/8/24 at 10:00 a.m. Staff A said she worked 6:00 a.m. to 2:00 p.m. that day and was assigned to the area that Tenant C1 resided. There were no concerns provided from third shift at shift change related to Tenant C1. At about 6:00 a.m. or 6:30 a.m., she thought 6:30 a.m., she gave him his medications, took his blood pressure and weighed him. When she first went into the room he was not dressed, he was seated on the side of the bed and looked weak. She said normally he was dressed. She weighed him and he could barely move, she put the scale close to the bed. He was not able to get dressed. The blood pressure cuff was not working and indicated there was an error. She said he had labored breathing during the the whole process and labored breathing when on his back. She went to get a different blood pressure cuff and Staff B came into the apartment with her at 6:40 a.m. Tenant C1's blood pressure was 88/63 at that time. At 6:42 a.m. she was trying to call the LPN to report he the labored breathing but when she reached her Tenant C1 had already passed. She said about 6:45 a.m. Staff A went into the apartment and he raised up took a breath, raised up again and laid back down. She told Staff B he needed to go to the hospital, Staff B went into the apartment and Tenant C1's companion reported	A 150		

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he was not responding. Staff B said that Tenant C1 was gone at 6:48 a.m. She was calling the LPN to tell her he needed to go to the hospital and then told her he had already passed. She said it was her first call to the LPN that morning and she had not called previously to report his blood pressure to her. The LPN came down and she checked on him and Staff B ensured his companion was out of the apartment. The LPN went to make telephone calls. Staff A called the Director of Long Term Support and Services to report that Tenant C1 had died. The Delegating Nurse and Director of Long Term Support and Services both arrived. She said the fire department came and they had asked questions. She did not remember what his code status was and said it would be in his service plan. She reported the fire department did not ask about his code status. She said the medical examiner spoke with her. She said Tenant C1's family arrived about 10:00 a.m. or 10:30 a.m. Regarding Tenant C1, she said it happened all of the sudden and they had just found out he had CHF. She did not know who called 911 but she did not call 911. She said she was under the impression it had to go through the nurse to call 911. Staff A felt he needed to go to the hospital and if she knew she could have called an ambulance she would called to have him taken. She estimated it was 15 minutes from when she first went into his apartment until the telephone call to the LPN. She said if staff observed changes with a tenant they reported it to the nurse.

When interviewed on 8/8/24 Staff B said she worked 6 a.m. to 2 p.m. that day but not assigned to Tenant C1's area. She said at 6:30 a.m. Staff A said her blood pressure cuff was not working and she asked Staff B to assist. Staff B went into

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the apartment and Staff A was jittery. Tenant C1 was joking with staff and they took his blood pressure which was low. Staff B asked Staff A to reach out to the nurse on 4th floor (Custom Care). Staff B said Tenant C1 was very pale in color and seemed very weak. She did not observe any SOB. She said the LPN was notified by Staff A right away at 6:35 a.m. and staff were to hold the Lasix. She returned to her area and about five to six minutes later and Staff A walked in and she was going to reach out to the nurse because he was not doing well. His companion was in the apartment. Staff B went to the apartment and the companion said he was not responding. Staff B checked and no pulse was found at 6:48 a.m. She took the companion into the living area and shut his door. Staff A was talking to the LPN when she walked in and Staff A reported to the LPN that Staff B thought he had passed. The LPN responded in three to five minutes. She said first responders arrived at about 6:50 a.m. or 6:55 a.m. The LPN had called them. She said fire department asked for the information book and it was taken to them. Tenant C1 had switched to a DNR. They called a hospital and said the time of death. She said Tenant C1 had been sick the week prior, he had pneumonia and was retaining fluid. She said if a tenant fell and hit their head staff could call 911 and then call the nurse. They would notify the nurse of low blood pressure or oxygen.

When interviewed on 8/8/24 at 11:37 a.m. Staff C she worked 6 a.m. to 2:00 p.m. that day but was not assigned to Tenant C1's area. She did not see Tenant C1 that morning and Staff A waived for her to come over and said that Tenant C1 had left. She went into the apartment and he had died. It was before 7:00 a.m. Staff C asked what happened and Staff A said she had given him his

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medications and had come back to take his weight and something was not right with him and she called Staff B. Staff C asked if the LPN had already been called and she had. The LPN arrived about five to six minutes later and she confirmed Tenant C1 was not living. She said about 7:00 a.m. or so first responders arrived. She said staff would notify the nurse if there was anything unusual with a tenant. Staff were allowed to call 911 if staff realized it was too bad, but normally would call the nurse. She said Tenant C1 had been a full code and it was changed a few days prior to DNR.

When interviewed on 8/7/24 at 1:15 p.m. the LPN said the Custom Care nurse was on-call for the Program. She said Staff A called her and reported Tenant C1's blood pressure of 88/63. She immediately sent a text message at 6:42 a.m. to Tenant C1's PCP and told her his blood pressure was 88/63 and the pulse was 96. The PCP responded back to hold the Lasix and asked if she had listened to his lungs. She told the PCP she was not there. The LPN called Staff B and told her to hold the Lasix. Shortly after that at 6:54 a.m. Staff A called and said Tenant C1 was unresponsive and that he needed to go to the hospital. She said she would get her keys and would be down. When she was in the stairwell either Staff A or Staff B called her back at 6:56 a.m. and said he was gone. When she arrived to the building Staff A, Staff B and Staff C were in the apartment and it was obvious he was deceased. She took his blood pressure and pulse. He was in bed and had a blanket on. She had staff leave and lock the door. The LPN contacted the PCP at 7:02 a.m. to inform her and she asked if the LPN had called family and said to notify them. She called Tenant C1's family and family wanted to see him. The LPN called Staff B

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to ensure he was presentable. She called the Delegating Nurse at 7:22 a.m. who said to call 911, she called and reported a tenant had passed away. She said the PCP did not feel the medical examiner needed to be notified and the Delegating Nurse said the medical examiner did need to be notified. The medical examiner was called. The first call she received that morning from Staff A was before she sent the text message to the PCP. Staff A did not report any symptoms or concerns with Tenant C1. She called Staff B back and told her to hold the Lasix and there were no other calls from staff and no reports of SOB or changes with Tenant C1. After Tenant C1 passed staff said he was up, took his medications and vitals and was laughing. There were no concerns or changes with him shared by staff at that time. The LPN was not present when EMS or the medical examiner arrived. She said if a tenant was weak, had a fall, if vital signs were out of sort or breathing was out of sort staff should notify the nurse.

When interviewed on on 8/7/24 at 2:48 p.m. the Delegating Nurse said Tenant C1 had labs and his BNP was over 16000, the PCP called his family and gave a choice to send him to the hospital or hospice and he was taken to the hospital. At the hospital he was given Lasix intravenously and was sent home. She said his code status had changed (DNR) and it was in place at the time of his death. She said the next day it was discussed that he really should go the higher level of care on campus but they did not have any beds. It was decided to to put more nursing eyes on him and arrangements were made with a campus nurse and the Custom Care nurse to check on him and take his blood pressure. On Friday, the Delegating Nurse was off work and received a call from the LPN at 7:22

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a.m. and she reported Tenant C1 had died. The Delegating Nurse was not surprised based on his labs and he had severe heart failure. She asked the LPN to call his family and she said she needed to check to see if it was a medical examiner issue. A medical examiner staff was contacted and she was told it was an issue for the medical examiner office. She was told to call EMS. She called the LPN back to tell her to the medical examiner staff said they needed to call EMS. The Delegating Nurse said there was mass confusion and the fire department came out and she thought a doctor was there and pronounced him. The Delegating Nurse arrived at 8:15 a.m. and EMS was gone. She said the medical examiner came at about 9:15 a.m. or 9:30 a.m. and the funeral home came after. She said she was told by staff that staff weighed him and took his blood pressure which low. His weight was wrong too. He was back in bed. She said staff reported Tenant C1's companion came out of his apartment and said she could not get him to respond. Staff A went into the apartment and asked if he could to talk to her and he raised his head and starting saying something twice. He was not able to respond and she called the LPN. The LPN was on her way when staff called and told her he had died. She said he had been SOB with exertion, his oxygen saturation was always at 100% and heart rate was in the 90's. She said his heart was working so hard. She said that morning he had not had breakfast but had his medications. There were jeans and a shirt on the floor. She said the nurse should be notified of any mental status changes, physical status changes or anytime there was a change or refusal of medications. If she was in the building she would be notified, if she was not in the building staff called the nurse at Custom Care. She said a nurse would completed an evaluation

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and would notify 911 and family. She said direct care staff did not call 911.

When interviewed on 8/8/24 at 8:55 a.m. the Director of Long Term Support and Services said Staff A called her in the morning to let her know Tenant C1 had died. Staff A told her he seemed tired, the nurse was going on him and when she went back in he had passed away. Staff reported he had been joking around with staff. The nurse was going to check on him because he seemed tired. It was not an emergency situation and staff just wanted him checked out. The Director of Long Term Support and Services came in to help out. The LPN had called Tenant C1's family and they wanted to come in to see him. She checked with Staff B to ensure he was presentable. The Delegating Nurse arrived after her. She said there was confusion related to if the medical examiner needed to be contacted. The LPN had contacted the PCP who indicated it was not needed and the Delegating Nurse thought they did need to be contacted. She thought the medical examiner said an ambulance needed to be called and the LPN contacted the ambulance. She said she had to leave and the Delegating Nurse took care of the medical examiner and paramedics. She said his code status was a DNR. She said staff should call the nurse for anything, if there were falls or skin tears and non-emergent things. She said staff could call 911. She said Staff A did not not tell her why she took his blood pressure but staff were told if a tenant was not feeling well to take vitals and call the nurse.

4. Further record review of text messages and phone call logs from the nurse work phone indicated the following (Due to inconsistencies in staff interviews related to timeframe and

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A 150	Continued From page 11 notifications the text messages and call logs were requested to provide clarification) : -On 8/2/24 at 6:42 a.m. a message was sent from the LPN to the PCP that indicated his blood pressure was 88/63 and his pulse was 96. The PCP indicated to keep holding his Lasix that morning and see what the midodrine does. It was asked if she was still there and if she could listen to his lungs. The LPN responded that she was not there. -On 8/2/24 at 6:54 a.m. and 6: 56 a.m. there were incoming calls. It was noted on the call log after printer that the calls were from Staff A to the LPN. -On 8/2/24 at 7:02 a.m. there was an outgoing call from the LPN to the PCP. -On 8/2/24 at 7:22 a.m. there an an outgoing call from the LPN to the Delegation Nurse. -On 8/2/24 at 7:26 a.m. there was an incoming call from the PCP to the LPN. It was noted on the call log after printing that it was regarding if the medical examiner needed to be called. -On 8/2/24 at 7:30 a.m. there was an incoming call from the Director of Long Term Support and Services -On 8/2/24 at 7:36 a.m. and 7:43 a.m. there were incoming calls from the Delegating Nurse to the LPN. It was noted on the call log after printing that it was regarding the Delegating Nurse telling her to call 911 for an ambulance. 5. Continued record review revealed the Summoning Help policy and procedure indicated when it was apparent a tenant was in need to	A 150		

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ARBOR PLACE	1140 K AVENUE NW CEDAR RAPIDS, IA 52405

(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) COMPLETE DATE
A 150	Continued From page 12 medical help the staff would notify the Custom Care Nurse on duty, who would decide if it was needed to call 911. Staff stayed with the tenant until helped arrived, the nurse would instruct staff to gather needed paperwork, the nurse would contact family and the apartment door would be locked after the tenant and emergency staff had left. The Medical Emergencies policy and procedure indicated to ensure prompt attention to medical emergencies all medical emergencies should be reported as soon as possible to the Program nurse or Custom Care nurse. All falls must be reported. The nurse would explain the nature of the illness or condition and what signs and symptoms to look for or what type of first aid would be needed. The nurse would determine if it was necessary to contact the family. 6. When interviewed on 8/8/24 at 4:47 p.m. the Director of Long Term Support and Services confirmed all policies and procedures requested were provided.	A 150		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 8 Number of tenants with cognitive impairment: 7 Total census: 15 Complaint #122515-C was investigated and the following regulatory insufficiencies were cited:	A000		
A150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policy and procedure related to medical emergencies and summoning help. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 8/7/24 Tenant C1's file revealed Interdisciplinary Notes indicated the following: -On 7/29/24 staff reported Tenant C1 complained of shortness of breath (SOB) with exertion in the last 24 hours. There was rubbing noted in both lungs and 2+ edema was noted in his bilateral lower extremities. Tenant C1 did not have a	A150	1. How the program will correct the insufficiency: Arbor Place Delegating Nurse will perform staff education regarding nurse notification per our policies: 1. Medical Emergencies, and 2. Summoning Help. 1a. Staff will receive education specifically on notifying a nurse during change in tenant condition. Staff will receive education on what to say to the nurse about how the resident has changed in addition to vitals. 2. Measures taken to ensure this does not recur: Printed copies of normal ranges of vital signs are printed at each cottage (care area) for staff to determine if a tenants vital signs are out of range. 11/1/2024To ensure the problem does not recur, this education will be presented at the all staff meeting planned for July 30 and ongoing through QAPI program. 3. The program will monitor performance ongoing through out QAPI program. 4. The date by which the insufficiency will be corrected.	7/8/2025 7/8/2025 7/8/2025 7/9/2025 7/9/2025

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A 150	Continued From page 1 cough or fever. The primary care provider (PCP) was notified. -On 7/29/24 new orders were received for a complete blood count (CBD) with differential, brain natriuretic peptide (BNP), basic metabolic panel (BMP) and chest x-rays. -On 7/29/24 the PCP examined him and the lab results returned and were faxed to the PCP. -On 7/29/24 the x-ray returned and the results were sent to the PCP. The x-ray indicated congestive heart failure (CHF). New orders were received for Lasix 20 milligram (mg), daily weights report if his weight was up three pounds per day and repeat the BMP on 8/1/24. Orders were also received to take his blood pressure twice daily and report to the PCP if lower than 100/70. The PCP talked to the legal representative, discussed new orders and a possible change to the resuscitation status. He was currently a full code. -On 7/29/24 the results of Tenant C1's BMP were 16433 and the PCP spoke with Tenant C1's legal representative and gave the choice of hospice or hospitalization. The legal representative chose to take Tenant C1 to the hospital. -On 7/30/24 it was noted Tenant C1 returned from the hospital the previous evening. His lungs continued to have rubbing sounds in both sides. A report was given to the PCP. -On 7/30/24 changes were made to Tenant C1's Iowa Physician Orders for Scope of Treatment (IPOST) and he was Do Not Resuscitate (DNR) with limited interventions.	A 150		

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A 150	Continued From page 2 -On 7/31/24 it was noted Tenant C1 felt nauseous and Zofran was administered. His lung sounds were somewhat improved that morning, there was SOB with wheezing noted with exertion. -On 8/1/24 Tenant C1 was very tired and was seen by the PCP. A blood draw was completed for labs and the results were faxed to the PCP. A new order was received for midodrine 2.5 mg, by mouth at morning and noon. An order to repeat the BMP on 8/5/24 was also received. -On 8/2/24 staff reported Tenant C1 had passed. The PCP was notified. A Vital Stats document indicated on 8/1/24 at 6:45 a.m. Staff A entered his pulse was 96 and his blood pressure was 88/63 when seated. The Vital Stats document indicated Tenant C1's blood pressure was taken and was outside of parameters in timeframe of 7/30/24 to 8/1/24. A Physician's Telephone Order indicated on 8/1/24 and order was received for midodrine 2.5 mg, by mouth in the a.m. and at noon, in addition to taking his blood pressure twice daily while he was laying down. It was ordered to notify the PCP of blood pressure readings if below 100/70 or above 150/90. A Physician's Telephone Order indicated on 8/1/24 to hold Lasix 20 mg due to low blood pressure today. A fax to the PCP dated 8/1/24 indicated a telephone order read back indicated to hold Lasix on 8/2/24 in the a.m. 2. Continued record review of Tenant C1's file revealed no incident report, staff communication report, or additional documentation related to his sudden death completed by the Program. A Patient Care Record from the fire department who responded was obtained. The report	A 150		

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A 150	Continued From page 3 indicated on 8/2/24 at 7:40 a.m. they were dispatched to the Program for a cardiac arrest, when on the way an update was provided indicating, per Program staff, the tenant was not able to be helped. When arrived they were taken to the apartment by staff, the apartment door was locked. There was no staff present and the bedroom door was closed. The door was opened and Tenant C1 was lying on right side in bed. He was cool to the touch, had mottled skin and was deceased. The report indicated the staff that was still in the room said "I checked on him at 6, he was very short of breath, so I took this blood pressure." The staff also said at 6:30 a.m. she called another staff to verify it due to issues with the blood pressure cuff. At that time his blood pressure was 88/63 and she reported he was "really struggling to breathe." Staff then called the nurse and were told to get him up, weigh him and to hold his water pill. When staff went back at 6:48 a.m. he had died. Staff reported he was a full code. The hospital was called for a time of death which was 7:53 a.m. It was noted on the report that Tenant C1 died at 6:48 a.m. and emergency medical services (EMS) were called at 7:40 a.m. The report also indicated per dispatch and CNAs (staff) on scene the following timeline was provided: - 6:00 a.m. Tenant C1 struggled to breathe and vitals were obtained - 6:30 a.m. Another staff confirmed vitals were obtained and the nurse was notified. The nurse advised to weigh him and hold his water pill - 6:48 a.m. Tenant C1 was found deceased - 7:40 a.m. EMS was called - 7:45 a.m. EMS arrived on scene - 7:53 a.m. Doctor provided time of death	A 150		

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A 150	Continued From page 4 Although the staff who stated she checked on him at 6:00 a.m. in the Patient Care Report was not identified by name, per interview with Staff A she was the staff assigned to his area that day and she gave him his medications, weighed him, and initially took his blood pressure. She went to get Staff B when the blood pressure cuff was not working. It should also be noted Staff A signed off the administration of his morning medications and weight for 8/2/24 on the August 2024 medication administration record (MAR). 3. When interviewed on 8/8/24 at 10:00 a.m. Staff A said she worked 6:00 a.m. to 2:00 p.m. that day and was assigned to the area that Tenant C1 resided. There were no concerns provided from third shift at shift change related to Tenant C1. At about 6:00 a.m. or 6:30 a.m., she thought 6:30 a.m., she gave him his medications, took his blood pressure and weighed him. When she first went into the room he was not dressed, he was seated on the side of the bed and looked weak. She said normally he was dressed. She weighed him and he could barely move, she put the scale close to the bed. He was not able to get dressed. The blood pressure cuff was not working and indicated there was an error. She said he had labored breathing during the the whole process and labored breathing when on his back. She went to get a different blood pressure cuff and Staff B came into the apartment with her at 6:40 a.m. Tenant C1's blood pressure was 88/63 at that time. At 6:42 a.m. she was trying to call the LPN to report he the labored breathing but when she reached her Tenant C1 had already passed. She said about 6:45 a.m. Staff A went into the apartment and he raised up took a breath, raised up again and laid back down. She told Staff B he needed to go to the hospital, Staff B went into the apartment and Tenant C1's companion reported	A 150		

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A 150	Continued From page 5 he was not responding. Staff B said that Tenant C1 was gone at 6:48 a.m. She was calling the LPN to tell her he needed to go to the hospital and then told her he had already passed. She said it was her first call to the LPN that morning and she had not called previously to report his blood pressure to her. The LPN came down and she checked on him and Staff B ensured his companion was out of the apartment. The LPN went to make telephone calls. Staff A called the Director of Long Term Support and Services to report that Tenant C1 had died. The Delegating Nurse and Director of Long Term Support and Services both arrived. She said the fire department came and they had asked questions. She did not remember what his code status was and said it would be in his service plan. She reported the fire department did not ask about his code status. She said the medical examiner spoke with her. She said Tenant C1's family arrived about 10:00 a.m. or 10:30 a.m. Regarding Tenant C1, she said it happened all of the sudden and they had just found out he had CHF. She did not know who called 911 but she did not call 911. She said she was under the impression it had to go through the nurse to call 911. Staff A felt he needed to go to the hospital and if she knew she could have called an ambulance she would called to have him taken. She estimated it was 15 minutes from when she first went into his apartment until the telephone call to the LPN. She said if staff observed changes with a tenant they reported it to the nurse. When interviewed on 8/8/24 Staff B said she worked 6 a.m. to 2 p.m. that day but not assigned to Tenant C1's area. She said at 6:30 a.m. Staff A said her blood pressure cuff was not working and she asked Staff B to assist. Staff B went into	A 150		

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A 150	Continued From page 6 the apartment and Staff A was jittery. Tenant C1 was joking with staff and they took his blood pressure which was low. Staff B asked Staff A to reach out to the nurse on 4th floor (Custom Care). Staff B said Tenant C1 was very pale in color and seemed very weak. She did not observe any SOB. She said the LPN was notified by Staff A right away at 6:35 a.m. and staff were to hold the Lasix. She returned to her area and about five to six minutes later and Staff A walked in and she was going to reach out to the nurse because he was not doing well. His companion was in the apartment. Staff B went to the apartment and the companion said he was not responding. Staff B checked and no pulse was found at 6:48 a.m. She took the companion into the living area and shut his door. Staff A was talking to the LPN when she walked in and Staff A reported to the LPN that Staff B thought he had passed. The LPN responded in three to five minutes. She said first responders arrived at about 6:50 a.m. or 6:55 a.m. The LPN had called them. She said fire department asked for the information book and it was taken to them. Tenant C1 had switched to a DNR. They called a hospital and said the time of death. She said Tenant C1 had been sick the week prior, he had pneumonia and was retaining fluid. She said if a tenant fell and hit their head staff could call 911 and then call the nurse. They would notify the nurse of low blood pressure or oxygen. When interviewed on 8/8/24 at 11:37 a.m. Staff C she worked 6 a.m. to 2:00 p.m. that day but was not assigned to Tenant C1's area. She did not see Tenant C1 that morning and Staff A waived for her to come over and said that Tenant C1 had left. She went into the apartment and he had died. It was before 7:00 a.m. Staff C asked what happened and Staff A said she had given him his	A 150		

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A 150	Continued From page 7 medications and had come back to take his weight and something was not right with him and she called Staff B. Staff C asked if the LPN had already been called and she had. The LPN arrived about five to six minutes later and she confirmed Tenant C1 was not living. She said about 7:00 a.m. or so first responders arrived. She said staff would notify the nurse if there was anything unusual with a tenant. Staff were allowed to call 911 if staff realized it was too bad, but normally would call the nurse. She said Tenant C1 had been a full code and it was changed a few days prior to DNR. When interviewed on 8/7/24 at 1:15 p.m. the LPN said the Custom Care nurse was on-call for the Program. She said Staff A called her and reported Tenant C1's blood pressure of 88/63. She immediately sent a text message at 6:42 a.m. to Tenant C1's PCP and told her his blood pressure was 88/63 and the pulse was 96. The PCP responded back to hold the Lasix and asked if she had listened to his lungs. She told the PCP she was not there. The LPN called Staff B and told her to hold the Lasix. Shortly after that at 6:54 a.m. Staff A called and said Tenant C1 was unresponsive and that he needed to go to the hospital. She said she would get her keys and would be down. When she was in the stairwell either Staff A or Staff B called her back at 6:56 a.m. and said he was gone. When she arrived to the building Staff A, Staff B and Staff C were in the apartment and it was obvious he was deceased. She took his blood pressure and pulse. He was in bed and had a blanket on. She had staff leave and lock the door. The LPN contacted the PCP at 7:02 a.m. to inform her and she asked if the LPN had called family and said to notify them. She called Tenant C1's family and family wanted to see him. The LPN called Staff B	A 150		

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A 150	Continued From page 8 to ensure he was presentable. She called the Delegating Nurse at 7:22 a.m. who said to call 911, she called and reported a tenant had passed away. She said the PCP did not feel the medical examiner needed to be notified and the Delegating Nurse said the medical examiner did need to be notified. The medical examiner was called. The first call she received that morning from Staff A was before she sent the text message to the PCP. Staff A did not report any symptoms or concerns with Tenant C1. She called Staff B back and told her to hold the Lasix and there were no other calls from staff and no reports of SOB or changes with Tenant C1. After Tenant C1 passed staff said he was up, took his medications and vitals and was laughing. There were no concerns or changes with him shared by staff at that time. The LPN was not present when EMS or the medical examiner arrived. She said if a tenant was weak, had a fall, if vital signs were out of sort or breathing was out of sort staff should notify the nurse. When interviewed on on 8/7/24 at 2:48 p.m. the Delegating Nurse said Tenant C1 had labs and his BNP was over 16000, the PCP called his family and gave a choice to send him to the hospital or hospice and he was taken to the hospital. At the hospital he was given Lasix intravenously and was sent home. She said his code status had changed (DNR) and it was in place at the time of his death. She said the next day it was discussed that he really should go the higher level of care on campus but they did not have any beds. It was decided to to put more nursing eyes on him and arrangements were made with a campus nurse and the Custom Care nurse to check on him and take his blood pressure. On Friday, the Delegating Nurse was off work and received a call from the LPN at 7:22	A 150		

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A 150	Continued From page 9 a.m. and she reported Tenant C1 had died. The Delegating Nurse was not surprised based on his labs and he had severe heart failure. She asked the LPN to call his family and she said she needed to check to see if it was a medical examiner issue. A medical examiner staff was contacted and she was told it was an issue for the medical examiner office. She was told to call EMS. She called the LPN back to tell her to the medical examiner staff said they needed to call EMS. The Delegating Nurse said there was mass confusion and the fire department came out and she thought a doctor was there and pronounced him. The Delegating Nurse arrived at 8:15 a.m. and EMS was gone. She said the medical examiner came at about 9:15 a.m. or 9:30 a.m. and the funeral home came after. She said she was told by staff that staff weighed him and took his blood pressure which low. His weight was wrong too. He was back in bed. She said staff reported Tenant C1's companion came out of his apartment and said she could not get him to respond. Staff A went into the apartment and asked if he could to talk to her and he raised his head and starting saying something twice. He was not able to respond and she called the LPN. The LPN was on her way when staff called and told her he had died. She said he had been SOB with exertion, his oxygen saturation was always at 100% and heart rate was in the 90's. She said his heart was working so hard. She said that morning he had not had breakfast but had his medications. There were jeans and a shirt on the floor. She said the nurse should be notified of any mental status changes, physical status changes or anytime there was a change or refusal of medications. If she was in the building she would be notified, if she was not in the building staff called the nurse at Custom Care. She said a nurse would completed an evaluation	A 150		

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A 150	Continued From page 10 and would notify 911 and family. She said direct care staff did not call 911. When interviewed on 8/8/24 at 8:55 a.m. the Director of Long Term Support and Services said Staff A called her in the morning to let her know Tenant C1 had died. Staff A told her he seemed tired, the nurse was going on him and when she went back in he had passed away. Staff reported he had been joking around with staff. The nurse was going to check on him because he seemed tired. It was not an emergency situation and staff just wanted him checked out. The Director of Long Term Support and Services came in to help out. The LPN had called Tenant C1's family and they wanted to come in to see him. She checked with Staff B to ensure he was presentable. The Delegating Nurse arrived after her. She said there was confusion related to if the medical examiner needed to be contacted. The LPN had contacted the PCP who indicated it was not needed and the Delegating Nurse thought they did need to be contacted. She thought the medical examiner said an ambulance needed to be called and the LPN contacted the ambulance. She said she had to leave and the Delegating Nurse took care of the medical examiner and paramedics. She said his code status was a DNR. She said staff should call the nurse for anything, if there were falls or skin tears and non-emergent things. She said staff could call 911. She said Staff A did not not tell her why she took his blood pressure but staff were told if a tenant was not feeling well to take vitals and call the nurse. 4. Further record review of text messages and phone call logs from the nurse work phone indicated the following (Due to inconsistencies in staff interviews related to timeframe and	A 150		

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(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) COMPLETE DATE
A 150	Continued From page 11 notifications the text messages and call logs were requested to provide clarification) : -On 8/2/24 at 6:42 a.m. a message was sent from the LPN to the PCP that indicated his blood pressure was 88/63 and his pulse was 96. The PCP indicated to keep holding his Lasix that morning and see what the midodrine does. It was asked if she was still there and if she could listen to his lungs. The LPN responded that she was not there. -On 8/2/24 at 6:54 a.m. and 6: 56 a.m. there were incoming calls. It was noted on the call log after printer that the calls were from Staff A to the LPN. -On 8/2/24 at 7:02 a.m. there was an outgoing call from the LPN to the PCP. -On 8/2/24 at 7:22 a.m. there an an outgoing call from the LPN to the Delegation Nurse. -On 8/2/24 at 7:26 a.m. there was an incoming call from the PCP to the LPN. It was noted on the call log after printing that it was regarding if the medical examiner needed to be called. -On 8/2/24 at 7:30 a.m. there was an incoming call from the Director of Long Term Support and Services -On 8/2/24 at 7:36 a.m. and 7:43 a.m. there were incoming calls from the Delegating Nurse to the LPN. It was noted on the call log after printing that it was regarding the Delegating Nurse telling her to call 911 for an ambulance. 5. Continued record review revealed the Summoning Help policy and procedure indicated when it was apparent a tenant was in need to	A 150		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0065	A. BUILDING: _____ B. WING _____	C 08/08/2024

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A 150	Continued From page 12 medical help the staff would notify the Custom Care Nurse on duty, who would decide if it was needed to call 911. Staff stayed with the tenant until helped arrived, the nurse would instruct staff to gather needed paperwork, the nurse would contact family and the apartment door would be locked after the tenant and emergency staff had left. The Medical Emergencies policy and procedure indicated to ensure prompt attention to medical emergencies all medical emergencies should be reported as soon as possible to the Program nurse or Custom Care nurse. All falls must be reported. The nurse would explain the nature of the illness or condition and what signs and symptoms to look for or what type of first aid would be needed. The nurse would determine if it was necessary to contact the family. 6. When interviewed on 8/8/24 at 4:47 p.m. the Director of Long Term Support and Services confirmed all policies and procedures requested were provided.	A 150		