STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225455	A. Building B. Wing	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Craneville Rehabilitation and Skilled Care Cent	265 Main Street Dalton, MA 01226

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 - Immediate jeopardy to resident health or safety 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** 21753 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose advanced directives indicated he/she was a Full Code (in the event of cardiac or respiratory arrest, attempts at resuscitation will be initiated) and that he/she wanted to be transferred to the hospital for care, the Facility failed to ensure nursing staff provided adequate basic life support (BLS - a level of care for victims of a life threatening illness), including the need to take immediate steps to identify the residents code status and to promptly initiate the appropriate procedures for administering cardiopulmonary resuscitation (CPR) in accordance with the resident's advanced directives and physician's orders. On [DATE] at approximately 8:30 A.M., Resident #1 was found unresponsive, without a pulse or respirations, nursing staff failed to immediately and adequately perform basic life saving measures, including administration of CPR, which included ensuring Resident #1's airway was maintained. Upon arrival, Emergency Medical Services (EMS) noted and removed the resident's upper dentures that (unbeknownst to nursing staff) were lodged in the resident's throat, obstructing his/her airway. Resident #1 was then transferred to the Hospital Emergency Department for further evaluation and was pronounced dead at 9:35 A. M. Findings include: Review of the Facility Policy titled, Code Blue, dated [DATE], indicated that: - A Code Blue is a response to medical emergencies delivered by a licensed nurse within the scope of his/her practice, to provide immediate care or treatment to prevent further injury. - The Nurse assesses the Resident following current American Heart Association Guidelines. - The Nurse determines the code status of the Resident. - The Emergency Response Team consists of all licensed nurses in the Facility and Certified Nursing Aides (CNAs) for the unit the Code Blue is called. - The Emergency Leader is the first nurse who responds and assumes responsibility until a Nursing Supervisor or Emergency Medical Services arrives on the scene. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Emergency Leader coordinates the response and assigns duties such as: - Obtain the automated external defibrillator (AED), emergency cart, oxygen. - Call EMS, start paperwork. - Emergency supplies and equipment are located at the Unit 1 and Unit 3 nurses stations, and include an AED, Code Cart, and Oxygen. The Facility Policy titled Automatic External Defibrillator (AED), dated [DATE], indicated that the Facility will provide an AED for use by trained staff in the event of a sudden cardiac arrest of a resident. All nurses must maintain current certification to provide automated external defibrillation. Review of the Massachusetts Board of Registration of Nursing Advisory Ruling on Nursing Practice, titled Nursing Practice and Cardiopulmonary Resuscitation, revised ,d+[DATE], indicated that to guide the decision making of the nurse, in the context of practice in all settings where healthcare is delivered require initiating cardiopulmonary resuscitation when a patient has been found unresponsive and has not yet been declared dead by a provider authorized pursuant to M.G.L c. 469 except when the patient has a current valid Do Not Resuscitate (DNR) order/status. American Heart Association 2020 guidelines indicated that the delivery of quality cardiopulmonary (CPR) improves a victim's chances of survival. The critical characteristics of quality CPR include: - If a victim is found unresponsive and in cardiopulmonary arrest, activate emergency response, and get a defibrillator. - Start compressions within 10 seconds of recognition of a cardiac arrest. - Push hard, push fast. Compress at a rate of at least 100/min. - Allow complete chest recoil after each compression. - Give effective breaths that make the chest rise. - After CPR begins, use an AED as soon as it is available, check the heart rhythm to evaluate if there is a shockable rhythm. AED's can greatly increase the chance of survival. - When a cardiac arrest occurs, the human brain can only survive 4 to 6 minutes without oxygen. After 6 minutes irreversible brain damage or death occurs, but timely CPR can restart the heart and get the victim breathing again. Review of Resident #1's Advance Directives, documented on his/her Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) Form, dated [DATE] and signed by Resident #1, indicated he/she was a Full Code, and for staff to Attempt to Resuscitate (administer CPR), intubate, ventilate and to transfer to the Hospital, if needed. Review of Resident #1's Physician Orders, dated [DATE], indicated to Attempt Resuscitation. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Admission Minimum Data Set (MDS), dated [DATE], indicated Resident #1 was cognitively intact (with a Brief Interview for Mental Status (BIMS) score of 14, range of 13 to 15 points indicates intact cognition), self-understood and understands others, had diagnoses of coronary heart disease, hypertension, and diabetes. During an interview on [DATE] at 9:45 A.M. and a follow-up interview at 2:47 P.M., Certified Nurse Aide (CNA) #1 said on [DATE] at approximately 8:30 A.M., she (CNA #1) and CNA #2 went back to Resident #1's room to pick up his/her breakfast tray and found Resident #1 unresponsive, and not breathing. CNA #1 said she stayed at Resident #1's side while CNA #2 went to get the nurse. During an interview on [DATE] at 12:40 P.M., CNA #2 said on [DATE] at approximately 8:30 A.M., after finding Resident #1 unresponsive, she (CNA #2) went to get help and told Nurse #1 that Resident #1 was unresponsive. CNA #2 said she and Nurse #1 went to Resident #1's room and Nurse #1 assessed him/her. CNA #2 said Nurse #1 then left the room, said she went with Nurse #1, and that Nurse #1 went to the computer at the nurse's station to look up Resident #1's code status in the e-record (electronic record). CNA #2 said Nurse #1 told her to call a Code Blue. CNA #2 said she couldn't find the code blue telephone number, so she called another unit instead and spoke to Nurse #3, who then called the Code Blue via overhead page. CNA #2 said the last time she had any training for a Code Blue, was a year ago, and that she forgot what she she supposed to do. CNA #1 said after Nurse #1 assessed Resident #1, she (Nurse #1) and CNA #2 left the room, so she was alone again with Resident #1, and that it seemed like a long time before anyone came back. CNA #1 said that at some point she went to the doorway and called out Code Blue so help would come. The Nursing Progress Note, dated [DATE] at 4:20 P.M., written by Nurse #1, indicated Resident #1 was found unresponsive by a CNA (time not documented), who notified this writer (Nurse #1), resident was assessed, and then another Nurse immediately started CPR, a Code Blue and 911 was called. The Note indicated CPR was continued until EMS arrived and took over Resident #1's basic life support. Review of Nurse #1's Written Witness Statement, dated [DATE], indicated she was told by a CNA that Resident #1 was unresponsive, she rushed to his/her room and assessed Resident #1 who was unresponsive and in cardiopulmonary arrest with agonal breathing (an ineffective breathing requiring resuscitation). The Statement indicated she (Nurse #1) then walked over to the nurse's station to check the e-record for Resident #1's code status, noted he/she was a full code, and then told CNA #2 to call a Code Blue. The Statement indicated she (Nurse #1) then called 911 and reported that CPR was in progress, and then went back to Resident #1's room. During an interview on [DATE] at 7:45 A.M., Nurse #1 said after she assessed Resident #1 as being unresponsive and in cardiopulmonary arrest, she left the room to go to the Nurse Station to access the e-record to determine Resident #1's code status. Nurse #1 said when she left the room, only CNA #1 was in the room, that there was not a nurse in the room at that time. Nurse #1 said she left the room to look up Resident #1's code status in the e-record, that it took her two to five minutes to determined he/she was a Full Code, and then she called 911 to activate EMS. Nurse #1 said by the time she returned to Resident #1's room, Nurse #2 and CNA #1 (not certified in CPR) were performing CPR. Review of the initial EMS Dispatch Call Audio Recording of the 911 call made by Nurse #1 from the Facility, dated [DATE] and time stamped 8:37 A.M., indicated the Dispatcher asked the following questions, and the Nurse responded: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dispatcher: 911, This call is recorded, what is your emergency? Nurse #1 said, I need you at (Facility name). Dispatcher: Okay, (repeated Facility name). Nurse #1: Yes. (silence) Dispatcher: Okay. (3 second pause) What's going on? Nurse #1: Oh, a person is not responding. Dispatcher: What? Nurse #1: A resident here is not responding, we are trying to resuscitate him/her. Dispatcher: Okay, is the resident breathing? Nurse #1: Not really, he/she breathes once and a while. Dispatcher: Okay, is CPR in progress? Nurse #1: Yes, it's CPR in progress. When the 911 Dispatcher asked Nurse #1 the Resident #1's age, room number and the Facility's telephone number, Nurse #1 did not know the answers and had to ask others. Review of a second EMS Dispatch Call Audio Recording of the 911 call Nurse #3 made from the Facility, dated [DATE] and time stamped 8:41 A.M., indicated Nurse #3 said, We are currently doing CPR on Resident #1, he/she is a full code and is unresponsive. The Dispatcher said We have an ambulance responding, they should be there momentarily. During interviews on [DATE] at 7:45 A.M. and at 3:04 P.M., Nurse #1 and Nurse #2 said Resident #1's code was their first actual code and said they did not have any mock code experience, and said there was no Nursing Supervisor in the Building for assistance with Resident #1's cardiopulmonary arrest. Review of Nurse #2's Written Witness Statement, undated, indicated on [DATE], when Resident #1 had a cardiopulmonary arrest, she was on another unit, she left her unit and went downstairs to Resident #1's room and assessed him/her. The Statement indicated that she (Nurse #2) assessed Resident #1 for a carotid pulse (pulse in his/her neck), breathing and performed a sternal rub (rubbing the breastbone with the knuckles vigorously to establish unresponsiveness). The Statement further indicated there was no response from Resident #1, and she called to a CNA (exact CNA unknown) to call 911 and that she remained in the room performing CPR with CNA #1 and directing staff. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:04 P.M. and on [DATE] at 1:45 P.M., Nurse #2 said she responded to the overhead Code Blue page regarding Resident #1. Nurse #2 said when she got to Resident #1's room, that no other nurses were in the room, that just CNA #1 was there. Nurse #2 said she was the first nurse to initiate CPR, and said she had to instruct CNA #1 on how to perform ventilation's with the ambu-bag. Nurse #2 said the Ambu bag was not working to ventilate Resident #1 and said CNA #1 attempted to ventilate Resident #1 with the Ambu bag three times without success. Nurse #2 said for the 4th attempt, she (Nurse #2) tried and used more force when squeezing the Ambu bag, that it then made a popping sound and deflated (this would occur secondary to the pressure and resistance from a potential airway obstruction). The Surveyor asked Nurse #2, If the resident's chest does not rise when giving rescue breaths, what do you do? and she said, reposition the airway. However, Nurse #2 said she did not recognize that the reason the chest was not rising was potentially due to an airway obstruction, (which would require the rescuer to look in the residents' mouth for a possible airway obstruction). Nurse #2 said if the resident's chest does not rise during CPR, then you would just continue to do chest compressions. Nurse #2 said when they performed CPR on Resident #1, who was lying in bed, there was no back board under him/her (as required for effective cardiac compressions). CNA #1 said while Nurse #2 performed chest compressions, CNA #5 arrived to the room with the code cart and the AED. CNA #1 said CNA #5 opened the AED bag and said there were no defibrillator pads for the AED. CNA #1 said no-one else in the room, including the nurses checked to see if there were AED pads. CNA #1 said that the CNAs are not familiar with the AED, because they do not receive training with the AED. CNA #1 said that CNA #5 kept saying nothing is working on the code cart. CNA #1 said after the Code Blue was over (Resident #1 was transferred to the Hospital by EMS) that the pads for the AED were found with the AED. During an interview on [DATE] at 2:18 P.M., Paramedic #1 said when performing CPR, the golden measure for assessing for an airway obstruction is, if the chest does not rise, reposition the airway, and if the chest still does not rise, then assess by looking in the mouth for an airway obstruction. Paramedic #1 said when ventilating with an Ambu bag, if there is resistance, pressure against the bag (indicating an airway obstruction) this will cause the pressure valve to release, often sounding like a pop. CNA #1 said after she and CNA #2 found Resident #1 unresponsive and CNA #2 went to get the nurse, that she was the only other person in Resident #1's room, until Nurse #2 arrived. CNA #1 said she was not certified in CPR, said Nurse #2 had to instruct her on how to ventilate him/her using the Ambu bag. CNA #1 said she attempted to ventilate Resident #1 with the Ambu bag three times unsuccessfully, that his/her chest was not rising, so Nurse #2 then attempted to ventilated him/her with the Ambu bag, but Resident #1's chest still did not rise. CNA #1 said it was only herself and Nurse #2 who performed CPR on Resident #1 until EMS arrived. Nurse #1 said when she returned to Resident #1's room, Nurse #2 and CNA #1 were performing CPR, and that she tried to assemble a non-rebreather mask during the code, but the oxygen tubing would not fit. Nurse #1 said she was not educated on the usage of the non-rebreather mask. Nurse #1 said she wanted to use the non-rebreather mask on Resident #1 because he/she was in cardiopulmonary arrest. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	However, the use of a non-rebreather mask would have been contraindicated in this situation. A non-rebreather mask would only be used on a patient/resident that was able to breathe on their own, unassisted, to provide supplemental high flow oxygen administration. Nurse #1 said she and CNA #3 tried but could not connect the oxygen tubing to the oxygen cylinder, and they could not turn the oxygen cylinder on, so Resident #1 was not administered oxygen during the code. Paramedic #1 said when performing CPR, that an Ambu bag with just room air has 21% oxygen, while an Ambu bag connected to an oxygen tank can attain approximately ,d+[DATE]% oxygen, so connecting the Ambu bag to oxygen was essential. Nurse #1 said she believed that for a person (resident) in cardiopulmonary arrest, brain damage starts after 60 minutes. However, according to the American Heart Association (AHA,) brain injury from a cardiopulmonary arrest starts within 4 to 6 minutes. Review of Resident #1's Facility Investigation, dated [DATE], indicated the Director of Nurses (DON) was informed by Nurse #3 that the Code Blue for Resident #1 did not go well. The DON checked the equipment on the code carts and AED that were used in the code. The Investigation indicated the DON found that the AED pads were in place with the AED, although staff did not pull the seal to release the pads. Review of the Ambulance Run Report, dated [DATE] at approximately 8:38 A.M., indicated that a 911 call was received from the Facility for a resident who was unresponsive, and CPR was being performed. The Report indicated EMS was at resident's bedside at 8:44 A.M., Nurse #2 was performing mouth to mouth resuscitation without a BSI barrier (body substance isolation to protect the rescuer and resident from infection), without an airway device, and chest compressions. The Report indicated nursing staff reported that prior to the EMS arrival, defibrillation was not performed due to having no AED pads available at the Facility. The Report further indicated an Emergency Medical Technician (EMT) discovered Resident #1's upper dentures were an obstruction in his/her airway, they were cleared manually, then the EMT took over chest compressions, obtained the Ambu bag from staff, and began ventilation's. The Report indicated staff said they were unable to connect the Ambu bag to the oxygen. The EMT applied an AED and no shock was advised. The EMT delivered oxygen (with an Ambu bag) 15 LPM (liters per minute). Compressions were performed until the LUCAS device (a machine that delivers chest compressions) was applied. Advance Cardiac Life Support (ACLS) arrived, used IO (intraosseous) vascular access (placement of a specialized hollow bore needle through the cortex of the bone into the medullary space for infusion of medical therapies) for immediate line access for fluids, an ET (Endotracheal tube - a tube in the mouth and throat) was inserted, and a cardiac monitor was applied. The Hospital Physician's Note, dated [DATE], indicated Resident #1 was in cardiopulmonary arrest on arrival, ACLS with 4 rounds of Epinephrine (a medication to stimulate the heart) in route to the Emergency Department (ED), and he/she remained in asystole (no cardiac electrical activity, flat line). The Note indicate that in the ED he/she was administered epinephrine, was defibrillated twice, his/her pupils remained fixed and dilated with no cardiac activity, and he/she was pronounced dead. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Death Certificate indicated his/her date and time of death was [DATE] at 9:35 A.M., the cause of death was a cardiopulmonary arrest, due to the consequence of peripheral vascular disease and coronary artery disease. During an interview on [DATE] at 12:00 P.M., the Staff Development Coordinator (SDC) said that she ensures that newly hired nurses have current healthcare provider CPR cards, and that during the nurses orientation she reviews the contents of the code cart with them, and demonstrates to the orientees how to turn on and off the oxygen cylinder with the wrench on the code cart. The SDC said the facility did not conduct mock code blue drills on a regular basis. The SDC said that prior to the [DATE] Code Blue, the facility did not provide return demonstration hands on training for nursing staff related to Code Blue and use of lifesaving medical equipment. The SDC said conducting mock code blue drills was critical to helping staff be prepared to respond in an emergency situation. The SDC said that there had only been one mock code blue conducted in the facility in 2022, and that it was conducted prior to Nurse #1 and Nurse #2 being hired. The SDC said she was unable to provide any supporting documentation to show that Nurse #1 or Nurse #2 had participated in or received training regarding mock code blue drills since they started working in the facility. The SDC said Nurse #1 and Nurse #2 had not received mock code blue drill experience in the Facility, prior to the [DATE] Code Blue. The SDC said both Nurse #1 and Nurse #2 were relatively new nurses and had only started working in the facility in 2022. The SDC said the Nurse #1 (newly hired in [DATE]) and Nurse #2 (newly hired in February 2022) did not have hands on experience with turning on and off the oxygen cylinder on the code cart, nor with connecting the oxygen tubing. The SDC said there was no education with the non-rebreather mask at the Facility and said Nurse #1 should not have been trying to use the non-rebreather mask. Although the facility did not have a policy regarding mock code blue drills, conducting such drills provides staff with hands on experience and familiarity with their roles and responsibilities during a code, as well as the location and use of lifesaving medical equipment. During an interview on [DATE] at 11:00 A.M., the Director of Nurses said that [DATE], the date of Resident #1's Code Blue, was a weekend, and that there was no Nursing Supervisor on site, in accordance with Facility Code Blue Policy, to assist Nurse #1 and Nurse #2 with their first code. The DON said that when CNA #5 told the nurses (during the code) that there were no AED pads in the AED case, she would have expected that one of the nurses would have also checked for the AED pads. The Director of Nurses said she checked the code cart an hour after Resident #1's Code Blue had been conducted, found that the AED pads were present with the AED, and that there was oxygen in the oxygen tank. The DON said that the staff on during the day shift did not know how to open the oxygen tank with the cylinder wrench.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21753 Based on records reviewed and interviews, for one of three sampled Residents (Resident #1), the Facility failed to ensure nursing provided care and services that met professional standards of practice, related to monitoring and identify signs of a clinical change with a decline in condition, when on 12/02/22 and 12/03/22, Resident #1 exhibited signs of mental status changes, was lethargic, anxious, yelling out repeatedly, had new physician's orders for treatment with an antibiotic, which required nursing to monitor, obtain, and document a full set of vital signs every shift, while he/she was on an antibiotic and document them in the e-record, however it was not done. Findings include: The Facility's policy titled, Acute Change of Condition Guidelines, dated 6/2017, indicated that: - An acute change of condition is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral or functional domains. - Clinically important means a deviation that, without intervention, may result in complications or death. - Direct care staff, including Certified Nursing Aides, will be trained on recognizing subtle but significant changes in the resident and how to communicate these changes to the nurse, for example increased agitation, lethargy. The American Journal of Nursing: Volume 110 - Issue 5 - indicated that vital sign monitoring is a fundamental component of nursing care. Obtaining a resident's pulse, respirations, blood pressure, and body temperature are essential in identifying clinical deterioration and these parameters must be measured consistently and recorded accurately. Abundant research indicates that lapses in monitoring vital signs interferes with appropriate and timely interventions for deteriorating patients. Resident #1's Admission Minimum Data Set (MDS), dated [DATE], indicated Resident #1 was cognitively intact (with a Brief Interview for Mental Status (BIMS) score of 14, normal 13 to 15 points indicates intact cognition), made self-understood and understands others, had no rejection of care, had a diagnoses of coronary heart disease, hypertension, and diabetes. Review of Resident #1's Nursing Progress Note, dated 12/02/22 at 5:07 P.M., indicated that Resident #1 was administered Tylenol 650 mg by mouth for fever, and had a temperature greater than 101. Review of Resident #1's Nursing Progress Note, dated 12/02/22 at 5:33 P.M., written by Nurse #7 indicated that the Physician was contacted for Resident #1's change in mental status, he/she was lethargic and stated he/she did not feel right. The Physician ordered a urinalysis, it was obtained, and it was placed in the refrigerator, to be sent out in the morning. The Physician also ordered Augmentin (an antibiotic -Amoxicillin 500 mg with clavulanate 125 mg), and one tablet was administered this evening. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Physician's Order, dated 12/2022, indicated to administer Augmentin one tablet by mouth twice a day for (potential treatment of) a urinary tract infection. Review of the Medication Administration Record, dated 12/2022, indicated Augmentin one tablet by mouth was administered on 12/02/22 at 8:00 P.M. Review of Resident #1's medical record during the 3:00 P.M. to 11:00 P.M. shift, indicated there was no documentation to support that, for Resident #1's change in condition and for the administration of an antibiotic, that a full set of vital signs was performed, which would include a pulse, blood pressure and an oxygen saturation level (amount of oxygen in his/her blood stream normal greater than 93%). During an interview on 1/04/23 at 9:43 A.M., Nurse #7 said on 12/02/22, he could not recall if Resident #1's vital signs (other than taking a temperature) were obtained, because if the computer system did not prompt him to obtain vital signs, then he would not obtain them. Review of Resident #1's Nursing Progress Note, dated 12/03/22 at 6:55 A.M., written by Nurse #8, indicated that Resident #1 slept in long intervals, he/she had confusion and anxiety, he/she was repeatedly calling out, he/she had a temperature of 97.7 and he/she denied pain. Review of Resident #1's medical record during the 11:00 P.M. to 7:00 A.M. shift, indicated there was no documentation to support that for Resident #1's change in condition (repeatedly calling out and anxious) and for the administration of an antibiotic, that a full set of vital signs was performed. During an interview on 1/04/23 at 1:04 P.M., Nurse #8 said on 12/02/22, during the 11:00 P.M. to 7:00 A.M. shift, she performed vital signs, but did not document them. Nurse #8 said she was concerned about Resident #1's blood pressure because it was low. Nurse #8 said on 12/02/22 at 11:00 P.M., during the 3:00 P.M. to 11:00 P.M. shift change report, Nurse #7 told her he had spoken to the Physician who instructed him to continue monitoring Resident #1 and to send him/her to the hospital if he/she got worse. During an interview on 12/28/22 at 9:45 A.M., CNA #1 said on 12/03/22 at 8:00 A.M., after she finished Resident #1's morning care, Resident #1 said he/she felt funny, that she was not feeling well. CNA #1 said when she told Resident #1 he/she would be okay, Resident #1 said, No, I won't be okay. CNA #1 said she reported what Resident #1 said to Nurse #1, but said she (CNA #1) did not take Resident #1's vital signs. CNA #1 said when she and CNA #2 went back to pick up Resident #1's breakfast tray 30 minutes later, when they found Resident #1 unresponsive, not breathing, and his/her chest was not rising. Review of Resident #1's e-record Vitals Signs Summary, indicated a full set of vital signs had not been performed by nursing since 10/24/22 (which was a six week period of time). (continued on next page)

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	225455	A. Building B. Wing	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Craneville Rehabilitation and Skilled Care Cent	265 Main Street Dalton, MA 01226

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/28/22 at 11:00 A.M., the Director of Nurses (DON) said that when an antibiotic is ordered, this triggers an order set in the e-record for a full set of vital signs to be obtained every shift by nursing, which includes temperature, pulse, blood pressure and oxygen saturation level. The DON also said that when a resident states that they are not feeling well, this also is a trigger for a full set of vital signs to be taken by nursing. The DON said for all three circumstances that occurred, two shifts for antibiotic administration, and Resident #1's complaints of not feeling well, she would have expected a full set of vital signs would have been performed by nursing, and in the case of Resident #1, vital signs were not performed.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21753 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose advanced directives indicated he/she was Full Code, (staff to attempt Resuscitation in the event of cardiac or respiratory arrest) and to be transferred to the hospital, the Facility failed to ensure that nursing staff were competent in identifying a resident's code status and activating Emergency Medical Services (EMS) promptly as well as ensuring nursing staff had the skill sets needed to provided adequate basic life support (BLS - a level of care for victims of a life threatening illness), including administration of cardiopulmonary resuscitation (CPR) in accordance with the resident's advanced directives and physician's orders and utilizing emergency medical equipment which included the automated external defibrillator (AED) machine and oxygen. When on [DATE], at approximately 8:30 A.M., after Resident #1 was found unresponsive, without a pulse or respirations, nursing staff were unprepared to appropriately respond to a Code Blue. Nursing staff failed to immediately identify his/she code status and immediately initiate and adequately perform basic life saving measures, including the administration of CPR, and failed to appropriately use lifesaving medical equipment, the AED and oxygen, that was available to them on the Code Cart. Nursing staff that worked and responded to the Code Blue on [DATE], self-reported that the Code Blue for Resident #1 did not go well. EMS transferred Resident #1 to the Hospital Emergency Department (ED) for further treatment and was pronounced dead at 9:35 A.M. Findings include: Review of the Facility Policy titled Code Blue, dated [DATE], indicated the following: - A Code Blue is a response to medical emergencies delivered by a licensed nurse within the scope of his/her practice, to provide immediate care or treatment to prevent further injury. - The Nurse assesses the Resident following current American Heart Association Guidelines. - The Nurse determines the code status of the Resident. - The Emergency Response Team consists of all licensed nurses in the Facility and Certified Nursing Aides for the unit the Code Blue is called. - The Emergency Leader is the first nurse who responds and assumes responsibility until a Nursing Supervisor or Emergency Medical Services arrives on the scene. The Emergency Leader coordinates the response and assigns duties such as: - Obtain the AED, emergency cart, oxygen. - Call EMS, start paperwork. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Emergency supplies and equipment are located at the Unit 1 and Unit 3 nurses stations, and include an AED, Code Cart, and Oxygen. The Facility Policy, titled Automatic External Defibrillator, dated [DATE], indicated that the Facility will provide an AED for use by trained staff in the event of a sudden cardiac arrest of a resident. All nurses must maintain current certification to provide automated external defibrillation. The Facility Policy, titled Unwitnessed Cardiac Events, dated ,d+[DATE], indicated that documentation of the entire event will be captured on the Cardiac Arrest and Event Form. American Heart Association 2020 guidelines indicated that the delivery of quality cardiopulmonary (CPR) improves a victim's chances of survival. The critical characteristics of quality CPR include: - If a victim is found unresponsive and in cardiopulmonary arrest, activate emergency response, and get a defibrillator. - Start compressions within 10 seconds of recognition of a cardiac arrest. - Push hard, push fast. Compress at a rate of at least 100/min. - Allow complete chest recoil after each compression. - Give effective breaths that make the chest rise. - After CPR begins, use an AED as soon as it is available, check the heart rhythm to evaluate if there is a shockable rhythm. AEDs can greatly increase the chance of survival. - When a cardiac arrest occurs, the human brain can only survive 4 to 6 minutes without oxygen. After 6 minutes irreversible brain damage or death occurs, but timely CPR can restart the heart and get the victim breathing again. Review of Resident #1's Facility Investigation, dates [DATE], indicated the Director of Nurses was informed by Nurse #3 that the Code Blue for Resident #1 did not go well. Review of the Medical Record indicated there was no documentation to support, and the Facility was unable to provide documentation that nursing staff documented the code activities, according to Facility policy, Unwitnessed Cardiac Events, dated ,d+[DATE]. There was no documentation to support that, per Facility's Code Blue Policy, that there was Code Leader during Resident #1's Code Blue to assign duties to ensure that the staff's response to the code was appropriate. Review of Resident #1's Advance Directives, documented on a Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) Record, dated [DATE] and signed by Resident #1, indicated to Attempt to Resuscitate (CPR), intubate, ventilate and to transfer to the Hospital if needed. Review of Resident #1's Physician Orders, dated [DATE], indicated to Attempt Resuscitation. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:45 A.M. and at 2:47 P.M., CNA #1 said on [DATE] at approximately 8:30 A.M., she (CNA #1) and CNA #2 went to Resident #1's room to pick up his/her breakfast tray and found Resident #1 unresponsive, and not breathing. CNA #1 said she stayed with Resident #1 and CNA #2 went to get the nurse. During an interview on [DATE] at 12:40 P.M., CNA #2 said on [DATE] at approximately 8:30 A.M., she immediately went and told Nurse #1 that Resident #1 was unresponsive. CNA #2 said Nurse #1 went to Resident #1's room and assessed him/her, then said Nurse #1 left the room, and she went with her. CNA #2 said that left only CNA #1 in Resident #1's room with him/her. CNA #2 said Nurse #1 went to the computer at the nurse's station to look up Resident #1's code status in the e-record. CNA #2 said Nurse #1 told her that Resident #1 was a Full Code and for her (CNA #2) to call a Code Blue. CNA #2 said she did not know how to do an overhead page in the facility to call the Code Blue but did not tell Nurse #1 that. CNA #2 said that instead she called another unit, said she spoke to Nurse #3, told her what was going on, and said Nurse #3 called the Code Blue via overhead page. CNA #2 said the last time she had training on a Code Blue in the facility was a year ago, and that she had forgotten what she was supposed to do. Review of Nurse #1's Witness Statement, dated [DATE], indicated on [DATE] at approximately 8:30 A.M., when she assessed Resident #1, who was in bed, he/she was in cardiopulmonary arrest with agonal breathing (an ineffective breathing requiring resuscitation). The Statement indicated she (left Resident #1's room) walked over to the nurse's station to check the e-record for Resident #1's code status, which took two to five minutes, and determined he/she was a full code. The Statement indicated Nurse #1 told CNA #2 to call a Code Blue. The Statement also indicated Nurse #1 then stopped to and called 911, reported that CPR was in progress, and then went back to Resident #1's room, and that Nurse #2 and CNA #1 (not certified in CPR) were performing CPR. Review of the initial EMS Dispatch Call Audio Recording of the 911 call made by Nurse #1 from the Facility, dated [DATE] and time stamped 8:37 A.M., indicated the Dispatcher asked the following questions, and the Nurse responded: Dispatcher: 911, This call is recorded, what is your emergency? Nurse #1 said, I need you at (Facility name). Dispatcher: Okay, (repeated Facility name). Nurse #1: Yes. (silence) Dispatcher: Okay. (3 second pause) What's going on? Nurse #1: Oh, a person is not responding. Dispatcher: What? Nurse #1: A resident here is not responding, we are trying to resuscitate him/her. Dispatcher: Okay, is the resident breathing? (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #1: Not really, he/she breathes once and a while. Dispatcher: Okay, is CPR in progress? Nurse #1: Yes, it's CPR in progress. When the dispatcher asked Nurse #1 the Resident's age, room number and the Facility's telephone number, Nurse #1 did not know the answers and could be heard asking other staff members for the information. From the time Nurse #1 initially assessed Resident #1 as being unresponsive and in cardiac-arrest, approximately 6 minutes had gone by before she placed the first call made from the facility, at 8:37 A.M., to 911 Emergency Services. Nurse #1 also did not communicate to any of the other nurses, including Nurse #3, that she had called 911. Subsequently, approximately 2 minutes later, Nurse #3 made a second 911 call. Review of a second EMS Dispatch Call Audio Recording of the 911 call Nurse #3 made from the Facility, dated [DATE] and time stamped 8:41 A.M., indicated Nurse #3 said, We are currently doing CPR on Resident #1, he/she is a full code and is unresponsive. The Dispatcher said We have an ambulance responding, they should be there momentarily. During an interview on [DATE] at 9:45 A.M. and at 2:47 P.M., CNA #1 said on [DATE], after Nurse #1 came and assessed Resident #1, Nurse #1 left the room and she was the only staff person in Resident #1's room until the Code Blue was called. CNA #1 said Nurse #2, who worked on another unit, arrived after the Code Blue was called. CNA #1 said since she was not certified in CPR, Nurse #2 instructed her on how to ventilate Resident #1 with an Ambu bag. CNA #1 said she attempted to ventilate Resident #1, but his/her chest was not rising, and then Nurse #2 then attempted to ventilate Resident #1 with the Ambu bag, but his/her chest still did not rise. CNA #1 said during the Code Blue it was only herself and Nurse #2 who performed CPR on Resident #1 until EMS arrived. During an interview on [DATE] at 3:04 P.M. and on [DATE] at 1:45 P.M., Nurse #2 said she responded to the overhead Code Blue page regarding Resident #1. Nurse #2 said when she got to Resident #1's room, that there were no other nurses in the room, that just CNA #1 was there. Nurse #2 said she was the first nurse to initiate CPR, and said she had to instruct CNA #1 on how to perform ventilation's with the Ambu bag. Nurse #2 said the Ambu bag was not working to ventilate Resident #1, that they did not see his/her chest rise and said CNA #1 attempted to ventilate Resident #1 with the Ambu bag three times without success. Nurse #2 said for the 4th attempt, she (Nurse #2) tried and used more force when squeezing the Ambu bag, that it then made a popping sound and deflated. The Surveyor asked Nurse #2, If the resident's chest does not rise when giving rescue breaths, what do you do? and she said, reposition the airway. However, Nurse #2 said she did not recognize that the reason the chest was not rising was potentially due to an airway obstruction, (which would require the rescuer to look in the residents' mouth for a possible airway obstruction). Nurse #2 said if the resident's chest does not rise during CPR, then you would just continue to do chest compressions. Nurse #2 said when they performed CPR on Resident #1, who was lying in bed, there was no back board under him/her (as required for effective cardiac compressions). (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:18 P.M., Paramedic #1 said when performing CPR, the golden measure for assessing for an airway obstruction is, if the chest does not rise, reposition the airway, and if the chest still does not rise, then assess by looking in the mouth for an airway obstruction. Paramedic #1 said when ventilating with an Ambu bag, if there is resistance, this pressure against the bag (indicating an airway obstruction) will cause the pressure valve to release, often sounding like a pop. During interviews on [DATE] at 7:45 A.M. and at 3:04 P.M., Nurse #1 and Nurse #2 said Resident #1's code was their first actual code and said they had not had any mock code drill experience. Nurse #1 and Nurse #2 said there was no Nursing Supervisor in the facility at the time of the Code Blue to assistance with Resident #1's cardiopulmonary arrest. During an interview on [DATE] at 12:00 P.M. the Staff Development Coordinator (SDC) said (which included a review of Nurse #1, newly hired in [DATE], and Nurse #2, newly hired in February of 2022, employee records with the Surveyor), there was no documentation to support that either nurse had completed competencies related to Code Blue or had participated in mock code drills in the Facility. The SDC said mock code blue drills would have included the following: - Using the AED equipment and supplies (AED pads). - Opening an oxygen cylinder with the cylinder key. - Providing oxygen from the cylinder by adjusting the flow rate valve. - Connecting oxygen tubing to the Ambu bag and then to the oxygen cylinder. - Placing a back board (if not on a hard surface) under the resident for effective compressions. - Conducting Mock Codes. The SDC said that she ensures that newly hired nurses have current healthcare provider CPR cards, and that during the nurses orientation she reviews the contents of the code cart with them, and demonstrates to the orientees how to turn on and off the oxygen cylinder with the wrench on the code cart. The SDC said the facility did not conduct mock code blue drills on a regular basis. The SDC said conducting mock code blue drills was critical to helping staff be prepared to respond in an emergency situation. The SDC said that there had only been one mock code blue conducted in the facility in 2022, and that it was conducted prior to Nurse #1 and Nurse #2 being hired. The SDC said she was unable to provide any supporting documentation to show that Nurse #1 or Nurse #2 had participated in or received training regarding mock code blue drills since they started working in the facility. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The SDC said Nurse #1 and Nurse #2 had not received mock code blue drill experience in the Facility, prior to the [DATE] Code Blue. The SDC said the facility did not conduct mock code blue drills on a regular basis. The SDC said that prior to the [DATE] Code Blue, the facility did not provide return demonstration hands on training for nursing staff related to Code Blue and use of lifesaving medical equipment. The SDC said both Nurse #1 and Nurse #2 were relatively new nurses and had only started working in the facility in 2022. The SDC said the Nurse #1 (newly hired in [DATE]) and Nurse #2 (newly hired in February 2022) did not have hands on experience with turning on and off the oxygen cylinder on the code cart, nor with connecting the oxygen tubing. The SDC said there was no education with the non-rebreather mask at the Facility and said Nurse #1 should not have been trying to use the non-rebreather mask. Although the facility did not have a policy regarding mock code blue drills, conducting such drills provides staff with hands on experience and familiarity with their roles and responsibilities during a code, as well as the location and use of lifesaving medical equipment. Review of Nurse #2's Witness Statement, indicated on that [DATE], when Resident #1 had a cardiopulmonary arrest, she was on another unit, left her unit and went downstairs to Resident #1's room and assessed Resident #1 (he/she had already been assessed by Nurse #1, this was not communicated to Nurse #2). The Statement indicated Nurse #2 assessed Resident #1 for a carotid pulse (pulse in his/her neck), breathing and performed a sternal rub (rubbing the breastbone with the knuckles vigorously to establish unresponsiveness). The Statement indicated there was no response, that she called then out to a CNA to call 911 (exact CNA unknown) and she remained in the room performing CPR with CNA #1. (However, unbeknownst to Nurse #2, 911 had already been called by Nurse #1). CNA #1 said while Nurse #2 performed chest compressions, CNA #5 arrived to the room with the code cart and the AED. CNA #1 said CNA #5 opened the AED bag and said there were no defibrillator pads for the AED. CNA #1 said that the CNAs are not familiar with the AED, because they do not receive training with the AED. CNA #1 said no-one else in the room, including Nurse #1 or Nurse #2 checked to see if there were AED pads with the machine. CNA #1 said after the Code Blue was over (Resident #1 was transferred to the Hospital by EMS) that the pads for the AED were found with the AED. Nurse #1 said when she returned to Resident #1's room, Nurse #2 and CNA #1 were performing CPR, and said that she tried to assemble a non-rebreather mask during the code, but the oxygen tubing would not fit. Nurse #1 said she was not educated on the usage of the non-rebreather mask, but said she wanted to use the non-rebreather mask on Resident #1 because he/she was in cardiopulmonary arrest. However, the use of a non-rebreather mask would have been contraindicated in this situation. A non-rebreather mask would only be used on a patient/resident that was able to breathe on their own, unassisted, to provide supplemental high flow oxygen administration. Nurse #1 said she and CNA #3 tried but could not connect the oxygen tubing to the oxygen cylinder, and that they could not turn the oxygen cylinder on. Nurse #1 said Resident #1 was not administered oxygen during the code. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Paramedic #1 said when performing CPR, that an Ambu bag with just room air has 21% oxygen, while an Ambu bag connected to an oxygen tank can attain approximately ,d+[DATE]% oxygen, so connecting the Ambu bag to oxygen was essential. Nurse #1 said she believed that for a person (resident) in a cardiopulmonary arrest, brain damage starts after 60 minutes. However, according to the American Heart Association (AHA) brain injury from a cardiopulmonary arrest starts within 4 to 6 minutes. The Ambulance Run Report dated [DATE] at approximately 8:38 A.M., indicated that a 911 call was received from the Facility for a resident who was unresponsive and CPR was being performed. EMS were at resident's bedside at 8:44 A.M., Nurse #2 was performing mouth to mouth resuscitation without a BSI barrier (body substance isolation to protect the rescuer and resident from infection), without an airway device, and she was performing chest compressions. Nursing staff reported that prior to the EMS arrival, defibrillation was not performed due to having no AED pads available at the Facility. The Report indicated an Emergency Medical Technician (EMT) discovered Resident #1's upper dentures were an obstruction in his/her airway, they were cleared manually, then the EMT took over chest compressions, obtained the Ambu bag from staff, and began ventilation's. The Report indicated staff said they were unable to connect the Ambu bag to the oxygen. The EMT applied an AED and no shock was advised. The EMT delivered oxygen (with an Ambu bag) 15 LPM (liters per minute). Compressions were performed until the LUCAS device (a machine that delivers chest compressions) was applied. Advance Cardiac Life Support (ACLS) arrived, used IO (intraosseous - in joint spaces) for immediate line access for fluids, an ET (Endotracheal tube - a tube in the mouth and throat) was inserted, and a cardiac monitor was applied. The Hospital Physician's Note, dated [DATE], indicated Resident #1 arrived in cardiopulmonary arrest on arrival, ACLS with 4 rounds of Epinephrine (a medication to stimulate the heart) in route to the Emergency Department (ED), and he/she remained in asystole (no cardiac electrical activity, flat line). The Note indicated that in the ED he/she was administered epinephrine and defibrillated twice. and that his/her pupils remained fixed and dilated with no cardiac activity and he/she was pronounced dead. Review of Resident #1's Death Certificate indicated his/her date and time of death was [DATE] at 9:35 A.M., the cause of death was a cardiopulmonary arrest, due to the consequence of peripheral vascular disease and coronary artery disease. During interview on [DATE] at 11:00 A.M., the Director of Nurses (DON) said that the staff did not document the code activities during the code as per their Facility policy. The DON said Nurse #1 should not have left CNA #1 alone with Resident #1, that Nurse #1 should have stayed in the room with Resident #1 and should have delegated tasks to other staff. The Director of Nurses said she checked the code cart an hour after Resident #1's code and found that the AED pads were present with the AED, and that there was oxygen in the oxygen tank. The DON said that when CNA #5 said there were no AED pads in the AED case, she would expected that either Nurse #1 or Nurse #2 would have checked for the AED pads. The DON said that during Resident #1's Code Blue (on [DATE]), Nurse #1 and Nurse #2 did not have the competency and skill set needed to respond in a medical emergency, that she would expected.