STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555486	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALAMEDA HEALTHCARE & WELLNESS CENTER	430 WILLOW STREET ALAMEDA, CA 94501

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 0224 **Level of harm -** Actual harm **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement their policy and procedure that prohibits neglect by not providing services to necessary to avoid physical harm, and the policy and procedure that gave direction for emergency care, when one resident (1) in a sample of three had a significant change in her physical functioning. Resident 1 had shortness of breath, and fluctuating vital signs including one hour where a blood pressure could not be obtained, and one respiratory therapist (RT) placed Resident 1 on a mechanical ventilator with settings that were not ordered by the medical doctor (MD). The registered nurses (RN 1, 2) did not call 911 when Resident 1's condition deteriorated and when measures taken by respiratory therapist (RT) and RN 2 were not effective, nor upon the telephone request of Resident 1's son when he was notified of her condition change. Additionally, the facility failed to call 911 to send Resident 1 to the hospital when they could not obtain her blood pressure between 10 a.m., and 11 a.m. As a result of this neglect, Resident 1 did not have the benefit of acute hospital services when her heart stopped and she was pronounced dead, six and one half hours after her initial symptoms of shortness of breath first appeared. Findings: Resident 1 was a [AGE] year old woman who was admitted to the facility on [DATE] from the acute care hospital. According to a hospital record Critical Care progress note dated 1/4/15, Resident 1 had a past medical history of [REDACTED]. The resident was on [MEDICATION NAME], a medication which prevents blood clots from forming, which is a problem for people with [MEDICAL CONDITION]. Resident 1 stopped taking her [MEDICATION NAME] three weeks prior, and presented to the emergency department (ED) of her local hospital with a blood clot in her right arm. She had surgery on 12/21/14, to remove the clot which was blocking the blood flow to her right arm. On 12/22/14, the resident developed a large right middle cerebral artery (the large artery that delivers [MEDICATION NAME] blood to the brain) stroke (blockage of the artery preventing blood flow) which caused swelling of her brain, and was transferred to another hospital for a decompressive craniotomy, which is a neurosurgical procedure in which part of the skull is removed to allow a swelling brain room to expand without being squeezed. The resident also had a [MEDICAL CONDITION] (trach) surgically placed to create an opening through her neck into the windpipe to provide an airway and to remove secretions from her lungs. The physician's skilled nursing facility (SNF) admission orders [REDACTED]. The Physician order [REDACTED]. stopped and prolong life by all medically effective means. In a telephone interview with Resident 1's son on 2/3/15 at 10:25 p.m., he stated that he received a phone call from RN 1 between 10 and 10:18 a.m., on 1/18/15, to report that his mother was having trouble breathing and had a fever. He asked RN 1 if she had a stroke, and RN 1 told him, No, but the doctor had ordered some tests. The son stated that he told RN 1 that his mother should be in a hospital, and RN 1 told him that they could take care of his mother there in the facility. He stated that an hour or two later he received a call from the doctor (MD) and he asked the MD why his mother wasn't in the hospital? When he arrived at the facility his mother was lying in the bed with one eye open, and one eye closed and the tubing was hooked up. He thought she was still alive, but she was dead. He stated that he was very upset that his mother wasn't sent to the hospital. The nurse in charge of Resident 1, RN 2, on 1/18/15 stated in an interview on 2/4/15 at 1:30 p.m., that when she did her first rounds at 6 a.m., on 1/18/15, she noted Resident 1 was having rapid breathing so she notified RT. At 10 a.m., Resident 1's respirations were labored. She said she could see that something was wrong with the resident because of her altered breathing, and she had diaphoresis (sweating). RN 2 told RN 1 to call MD (the physician). RN 2 stated that the entries she made in her nurses notes were a reflection of the resident's condition and that she did not document the resident's vital signs, from 6 a.m., until the MD came in at 11 a.m. RN 2's nurse's note written on 1/18/15 contained the following entries: At 6 a.m., Resident 1 had increased anxiety and mild shortness of breath. Her vital signs were, BP 157/85, (normal range 90-140 (systolic) over 60-90 (diastolic)), temperature 98.6 degrees Fahrenheit (without fever), pulse 100 beats per minute (normal rate 60 to 100 beats per minute), respirations 18 breaths per minute (normal 12 - 20 breaths per minute), blood oxygen saturation was 100 percent. At 7 a.m., Resident 1'[MEDICAL CONDITION] suctioned with a minimum amount of pale yellowish secretions and her oxygen saturation ranged from 97 to 100 percent. At 10 a.m., Resident 1 had labored breathing and the respiratory therapist (RT) was at the bedside. The nursing supervisor RN 1 called the resident's physician, (MD) who said he was coming to the facility. RT placed the resident on a mechanical ventilator (a machine that generates a controlled flow of gas into the patient's airways) and administered the [MEDICATION NAME] nebulizer treatment via the [MEDICAL CONDITION]. The oxygen saturation was 97-100 percent. The resident (1) was noted with diaphoresis (sweating) and her blood sugar at the finger was elevated at 315 milligrams per deciliter (mg/dl) (normal 60-100 mg/dl). At 11:30 a.m., MD ordered a transfer to the acute hospital and the resident had, Very weak palpable pulse on both wrist, by RN 1 and RT; despite all treatments administered and given and (she) even was placed on (mechanical ventilator), pt. (Resident 1) continues to have SOB (shortness of breath); RT started bagging (ambu bag) on portable tank with O2 (oxygen); RN 1 called 911 .911 paramedics here and take over. At 12:39 p.m., Pronounced dead by MD with 911 paramedics . During an interview in the facility with RT on 2/3/15 at 3 p.m., he stated that he started Resident 1 on mechanical ventilation and was with RN 2. He stated that RN 1 called MD and he wasn't sure which of the nurses, RN 1 or RN 2 said, Put on mechanical ventilation per MD's orders; but he didn't see the written order. He agreed that he did not write progress notes in Resident 1's medical record, but provided a notebook containing a diary of notes regarding several residents titled Weekly Notes where he documented on Resident 1. According to RT's Weekly Notes, on 1/18/15 there was an entry for Resident 1 at 9:15 a.m., that he gave a [MEDICATION NAME] treatment for [REDACTED]. The entry further showed that Resident 1's heart rate was 109 beats per minute, and her respiration rate was 28 breaths per minute. The heart rate and respiration rates were both elevated above normal. In a telephone interview with RN 1 on 2/4/15 at 11:30 a.m., she stated that on that day (1/18/15) she called MD and he gave an order for [REDACTED]. pressure manually. She stated that Resident 1 had a pulse, but it was not documented in the medical record. RN 1 stated that she did not think that she needed to call 911 because MD was coming to the facility and, We were working on trying to get a blood pressure. In a telephone interview with MD on 2/4/15 at 10:15 a.m., he stated that he received a call from RN 1 on 1/18/15, that

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0224 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Resident 1 was having difficulty breathing. He told her he was going to finish rounds and then come to the facility. He did not recall giving a telephone order for mechanical ventilation or what the settings would be, he stated, RT knows the standard settings. He did not recall telling the nurse to keep Resident 1 in the facility until he arrived as opposed to calling 911, because that would be inappropriate. He further stated that the, Nurses are competent. They should know there is no demand that they must keep her (Resident 1) there (at the facility). MD wrote a progress note on 1/18/15, timed from 11:30 a.m. - 1 p.m., that showed Resident 1 had a decreased level of consciousness with stable vital signs at 11:30 a.m., but had no response and had to be ventilated. (MD's) discussion with family led to a decision to transfer to the hospital and 911 was called, but Resident 1's heart stopped beating and aggressive cardiopulmonary resuscitation was started. Called family, (they were) upset. Likely [DIAGNOSES REDACTED]. The Nurse Manager (RN 3) of the Subacute Unit where Resident 1 was receiving care, stated in an interview on 2/3/15 at 3:10 p.m., that there were no written orders from the physician (MD) for mechanical ventilation or for what the settings should be, and that RN 1 did not write any progress notes. RN 3 stated that she would have called 911 when it became apparent that the ventilator and breathing treatments didn't have an impact. She also said she would send a resident out to the hospital at the request of the family. A review of the facility's policy and procedure for, Change of Condition Notification dated 1/1/12, showed that, .In emergency situations .the Licensed Nurse will: Call the Attending Physician STAT; .If the resident deteriorates, the symptoms are serious .call 911 for transport to hospital . A review of the facility's undated policy and procedure titled Reporting Abuse to Administrator, which the Administrator provided on 2/24/15 at 2:30 p.m., showed the, Purpose (was) To protect residents from .neglect .by ensuring that all Facility personnel .report any incident or suspected incident of resident neglect .to the Administrator. Under the heading of Definitions, Neglect is described as, .Failure to provide medical care for physical and mental health needs .
F 0281 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess, monitor and follow their policy and procedure for one resident (1) in a sample of three, who had a significant change in her physical functioning with shortness of breath, altered level of consciousness, and severe pain. One registered nurse supervisor (RN 1) did not call 911 when Resident 1's condition became acute, requiring intensive monitoring and hospital-level treatment. Registered nurse (RN 2), who had bedside responsibility for Resident 1, did not document any vital signs for Resident 1, who at 6 a.m., had an elevated pulse (heart rate) of 100 beats per minute, until 11 a.m., when the physician (MD) was at the bedside. Respiratory therapist (RT) placed Resident 1 on a mechanical ventilator without a written physician's orders [REDACTED]. As a result of the failures of RNs 1, 2 and RT to provide professional standards of quality care, Resident 1 was not sent to the hospital and 911 was not called until the MD was in the building and ordered them to do so at 11:30 a.m. Resident 1 went into [MEDICAL CONDITION] (heart stopped beating) before 911 arrived and was pronounced dead at 12:39 p.m., in the facility. Cross-reference F309 Findings: Resident 1 was a [AGE] year old woman who was admitted to the facility on [DATE] from the acute care hospital. According to a [MEDICAL CONDITION] Critical Care progress note dated [DATE], Resident 1 had a past medical history of [REDACTED]. Resident 1 was on [MEDICATION NAME], a blood thinning medication which prevents blood clots from forming, a problem for people with [MEDICAL CONDITION]. Resident 1 stopped taking her [MEDICATION NAME] three weeks prior, and presented to the emergency department (ED) of her local hospital with a blood clot in her right arm. She had surgery on [DATE] to remove the clot, which was blocking the blood flow to her right arm. On [DATE] Resident 1 developed a large right middle cerebral artery (the large artery that delivers [MEDICATION NAME] blood to the brain) stroke (blockage of the artery preventing blood flow) which caused swelling of her brain, and was transferred to another hospital for a decompressive craniotomy, which is a neurosurgical procedure in which part of the skull is removed to allow a swelling brain room to expand without being squeezed. Resident 1 also had a [MEDICAL CONDITION] (trach) surgically placed to create an opening through her neck into the windpipe to provide an airway and to remove secretions from her lungs. The progress note further revealed that Resident 1 had a, Slow recovery in neurologic status. According to the physician's admission orders [REDACTED]elevated blood sugars, [MEDICATION NAME] ,[DATE] milligrams (mg) (a narcotic pain killer) every four hours as needed for severe pain, and [MEDICATION NAME] 0.5 mg (anti-anxiety medication) every four hours as needed for anxiety. The treatments ordered by the physician on [DATE] were [MEDICAL CONDITION] mist with oxygen at 5 liters per minute and to titrate (regulate the amount) the dose to maintain an blood oxygen saturation of greater than or equal to 92 percent, [MEDICATION NAME] nebulizer every four hours as needed for dyspnea (shortness of breath) or wheezing (in the lungs), and Ambu bag (a hand-held, self-inflating bag commonly used to provide positive pressure ventilation (push air into) for patients who are not breathing or not breathing adequately) at the bedside for emergency use. The Physician order [REDACTED]. stops and prolong life by all medically effective means. RN 2's nurses note written on [DATE] showed the following entries: At 6 a.m., Resident 1 had increased anxiety and was given a dose of [MEDICATION NAME] 0.5 mg., and had mild shortness of breath. Her vital signs were, BP ,[DATE], temperature 98.6 degrees Fahrenheit (without fever), pulse 100 beats per minute, respirations 18 breaths per minute, blood oxygen saturation was 100 percent. At 7 a.m., Resident 1'[MEDICAL CONDITION] suctioned with a minimum amount of pale yellowish secretions and her oxygen saturation ranged from 97 to 100 percent. At 8 a.m., Resident 1 was having pain assessed as 8 out of 10, (10 being the worst pain) and was given the medication [MEDICATION NAME] ,[DATE] mg for severe pain. (The note did not indicate where the pain was or if the treatment provided relief.) At 10 a.m., Resident 1 had labored breathing and the respiratory therapist (RT) was at the bedside. The nursing supervisor RN 1 called the resident's physician, (MD) who said he was coming to the facility. RT placed the resident on a Trilogy mechanical ventilator (a machine that generates a controlled flow of gas into the patient's airways) and administered the [MEDICATION NAME] nebulizer treatment via the [MEDICAL CONDITION]. The oxygen saturation was ,[DATE] percent and there were no other vital signs documented. The resident was noted with diaphoresis (sweating) and her blood sugar at the finger was 315 milligrams per deciliter (mg/dl) (normal ,[DATE] mg/dl) and she was given 8 units of regular insulin. At 10:30 a.m., Resident 1's blood sugar was rechecked and was 273 mg/dl. No vital signs were recorded. At 11 a.m., MD was at the bedside and assessed Resident 1, and vital signs were noted as, BP ,[DATE], pulse 85 and respirations 22, her oxygen saturation was 100 percent. MD ordered Intravenous (IV) fluids and antibiotics but the note reflected that the nurses could not start the IV line because she was a hard stick. At 11:30 a.m., MD ordered a transfer to the acute hospital and Resident 1 had, Very weak palpable pulse on both wrist, by RN 1 and RT; despite all treatments administered and given and even was placed on (mechanical ventilator) pt. (Resident 1) continues to have SOB (shortness of breath); RT started bagging (ambu bag) on portable tank with O2 (oxygen); RN 1 called 911 .911 paramedics here and take over. At 12:39 p.m., Pronounced dead by MD with 911 paramedics . There were no progress notes written by RN 1 or RT. MD wrote a progress note on [DATE] at 11:30 a.m., - 1 p.m., that showed Resident 1 had a decreased level of consciousness with stable vital signs at 11:30 a.m., but no response and had to be ventilated. (MD) Discussion with family led to a decision to transfer to the hospital and 911 was called, but Resident 1's heart stopped beating and aggressive cardiopulmonary resuscitation was started. (MD) Called family, (they were) upset. Likely [DIAGNOSES REDACTED]. During an interview with RT at the facility on [DATE] at 3 p.m., he stated that he started Resident 1 on mechanical ventilation and was with RN 2. He stated that RN 1 called MD and he wasn't sure which of the nurses, RN 1 or RN 2 said, Put on mechanical ventilation per MD's orders. Then MD came in and he checked her vital signs. RT said he was bagging the resident as well. RT went through Resident 1's medical record and stated there was no respiratory progress note for [DATE].

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F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) He then provided a Weekly Notes which contained written information on several residents that he kept in a notebook at the nursing station but not recorded in the medical record. According to RT's Weekly Notes, on [DATE] there were two entries for Resident 1. At 9:15 a.m. RT documented that he gave a [MEDICATION NAME] treatment for [REDACTED]. RN (1) called MD and was told to put Resident on ventilator. Placed Resident 1 on Triology vent passive a/c/ IU VT 500 peep 4 5 L O2 sat (saturation) 98, HR (heart rate) 109, RR (respiration rate) 28 @ 1027. Another entry at 11 a.m., showed, Pt's (Resident 1) vitals were stable .except RR (respiration rate) fluctuated to mid 30's. MD arrived and told nurse to start IVs @ 11:30. Pt (Resident 1) was getting bagged while the nurses were trying to start the IV. 911 was called; they checked for a pulse and stated CPR. Pt expired at 1230. A review of the facility's Job Description-Respiratory Staff Member, dated ,[DATE], .Records all pertinent information of treatments, and resident response to treatments, on respiratory care records and resident chart . In a telephone interview with MD on [DATE] at 10:15 a.m., he stated that he received a call from RN 1 that Resident 1 was having difficulty breathing. He told RN 1 he was going to finish rounds and then come to the facility. He did not recall giving a telephone order for mechanical ventilation or what the settings would be; he stated, RT knows the standard settings. He didn't recall telling RN 1 to keep the resident in the facility until he arrived, because that would be inappropriate. He further stated that the, Nurses are competent; they should know there is no demand that they must keep her (Resident 1) there (at the facility), (as opposed to calling 911 and sending her to the hospital.) Review of the the California Licensed Respiratory Care Practitioner Scope of Practice Business and Professions Code 3702 showed, .Respiratory care as a practice means a health care profession employed under the super vision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the [MEDICAL CONDITION] system and associated aspects of cardiopulmonary and other systems function, and inludes all of the following: .The diagnostic and therapeutic use of any of the following, in accordance with the prescription of a physician .mechanical or physiological ventilatory support . In a telephone interview with RN 1 on [DATE] at 11:30 a.m., she stated that on that day ([DATE]) Resident 1 was having shortness of breath, RT gave and breathing treatment and was monitoring the oxygen saturation levels which were O.K.'d. She stated that she called MD and he gave an order for [REDACTED]. RN 1 stated that Resident 1 had a pulse, but it was not documented in the medical record. RN 1 did not think that she needed to call 911 because MD was coming to the facility and, We were working on trying to get a blood pressure. RN 1 also stated that she did not write a progress note to record any of her actions, Resident 1's condition, nor MD's orders. During a visit to the facility on [DATE], RN 2 stated in an interview at 1:30 p.m., that when she did her first rounds at 6 a.m. on [DATE], she noted Resident 1 was having rapid breathing, so she notified RT. RN 2 thought it was anxiety and gave Resident 1 a dose of [MEDICATION NAME] and then around 7 a.m., Resident 1 was grimacing and so she gave her pain medication ([MEDICATION NAME]) based on her facial expression. RN 2 stated she knew something was wrong because of Resident 1's altered breathing, her diaphoresis (sweating) and her increased blood sugar. RN 2 stated that the machine was recording blood pressures, but that she did not write them down. According to the Board of Registered Nursing - Business and Professions Code 2725. .Practice of nursing defined .Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, or appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures or the initiation of emergency procedures. (c) 'Standardized procedures,' as used in this section, means either of the following: (1) Policies and protocols developed by a health facility . A review of the facility's Change of Condition Notification policy and procedure, dated [DATE], showeded .In emergency situations, (e.g., a resident is experiencing unexpected shortness of breath, intense pain, .) the Licensed Nurse will: Call the Attending Physician STAT; .If the resident deteriorates, the symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, call 911 for transport to hospital .