STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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** 19401 Based on observation, interview, and record review the facility failed to provide basic life support, including CPR to a resident requiring emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the residents advanced directives for 1 of 4 residents reviewed for emergency care (Resident #1) The facility failed to assess and immediately initiate CPR when Resident #1, who was a full code, was found unresponsive in the dining room on [DATE] at 7:10 a.m. CPR was not initiated until EMS arrived (12 minutes after the resident was found unresponsive). Resident #1 was transported to the hospital, found to have large amounts of solid food in his airway, and pronounced deceased on [DATE] at 9:18 a.m. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 6:10 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk for not receiving immediate emergency services (CPR) and death. Findings included: Review of Resident #1's face sheet with undated indicated he was a [AGE] year-old male initially admitted to the facility on [DATE] and his last readmitted was [DATE]. Some of his diagnoses were stroke, cognitive communication deficit, and seizure disorder. Record review of quarterly MDS dated [DATE] indicated Resident #1's cognitive status was severely impaired with a BIMS score of 5. He required substantial to maximal assist with eating, and oral hygiene. He was dependent for all other ADLs. Record review of Resident #1's care plan dated [DATE] indicated the following care areas: (continued on next page)

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.

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*At risk for choking related to seizure disorder requiring medications problem start date of [DATE] and last edited on [DATE] . The approaches were to monitor the resident frequently throughout the shift following seizure activity. To assess the resident after seizures, the time, length, level of consciousness, activity, and respiratory activity if a seizure occurred. *A mechanical soft diet due to a history of stroke with residual effects and contractors to bilateral hands problem start date of [DATE] . The approaches may have clothes protector during meals if desired, ensure a bedside table was provided in the ding area with meals for easy reach. Report problems to charge nurse such as choking or difficulty chewing. Someone to assist with feeding on days he had difficult feeding himself. *An advance directive problem start date of [DATE] and last edited [DATE]. The approach was full code. Record review of Resident #1's computerized physician orders indicated the following: *dated [DATE] for Full Code Status. *dated [DATE] for regular diet, mechanical soft with thin fluids. Record review of an EMS report dated [DATE] indicated at 7:16 a.m. dispatch received a call. The EMS were in route at 7:17 a.m. and arrived on the scene at 7:20 a.m. The report indicated they were at the patient at 7:22 a.m. and departed the scene at 7:30 a.m. The report indicated they were at the hospital at 7:37 a.m. The report indicated the Resident's primary impression was cardiac arrest with a reported-on set of 7:10 a.m. and a duration of 12 minutes. The report indicated on arrival on the scene they asked for directions to the patient, and the nursing staff pointed to a resident sitting in a wheelchair. The nurse who gave report stated he had breakfast at about 6:30 a.m. and when she approached him at 7:10 a.m. he was not responsive. There was no CPR initiated prior to EMS arrival. At 7:22 a.m. initial contact with the resident showed he was unresponsive, pulseless, and warm to touch. Record review of hospital records dated [DATE] indicated Resident #1 arrived at 7:38 a.m. with a diagnosis of Cardiac arrest with pulseless electrical activity. Resident #1's airway was assessed per guided scope and found to have large amounts of solid food throughout visible airway. The food products were noted in King airway(a tube used for intubation for advanced airway management) as well. Attempts to clear the airway via mechanical and suction removal. EMS stated the patient was sitting in a wheelchair at the nurse's station unresponsive with no CPR in progress when they arrived. The patent had just eaten breakfast. The exact down time is unknown. We were unable to replace the laryngeal mask airway (LMA a medical device that keeps a patient's air way open while they are unconscious) due to the amount of food in his trachea. (Windpipe). The patient was pulseless from the time of arrival to the time the MD pronounced him deceased . Compressions were stopped at 8:45 a.m. and he was pronounced by the physician at 9:18 a.m. as deceased . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nursing note dated [DATE] with a time of 7:50 a.m. but was created on [DATE] at 3:41 p.m. indicated, Resident #1 was up in his Geri-chair in the dining room for breakfast between 6:30 a.m. and 7:00 a.m. He was sitting up joking with the other residents in his usual manner. He consumed about 90 percent of his meal which consisted of oatmeal, eggs, and a biscuit. Kitchen Stall D, Kitchen Staff E and LVN B remained in the dining area while this nurse (LVN A) assisted another resident to his room. When nurse returned to the dining area Kitchen Staff D was loudly calling Resident #1's name and tapping him. The nurse performed a sternum rub and he did not respond. He had a significant history of seizures, hypoglycemia, and cardiac arrest. The nurse asked Kitchen Staff D to get LVN B and call 911 for help. LVN B called 911 and came to assist this nurse. The nurse proceeded to check the code status(to determine If he was a do not resuscitate or to perform CPR) and gather items needed to assess the resident while LVN B pushed the resident to the nursing station. Resident #1 was a Full Code(indicated the resident wished for the facility to provide every possible effort to save his life in a medical emergency including CPR). The nurse was unable to get vitals or arose the resident per verbal or tactile stimulation. EMS arrived and initiated CPR. The note indicated the responsible party was notified at 7:19 of the transfer to the hospital. and another entity was notified at 7:18 a.m. The note was written by LVN A. Record review of a nursing note dated [DATE] at 9:20 a.m. indicated the facility contacted the family for a report on Resident #1 and as informed the resident had expired. Record review of a timeline provided by the facility on [DATE] at 3:40 p.m. by the administrator undated indicated on [DATE] between 6:30 a.m. and 7:00 a.m. breakfast was served. LVN A was located in the dining room until 6:50 a.m. when she left to walk a resident back to his room and check on another resident. LVN B was in the dining room until approximately 7:00 a.m. and then gathered smokers to take them out to smoke. At 6:50 a.m. Kitchen Staff D and Kitchen Staff Kitchen Staff were eating their breakfast in the dining room. At 7:10 a.m. smokers came back inside, and Resident #1 appeared to be sleeping. Kitchen staff D went to Resident #1 to take him to the lobby and could not get him to respond. Staff loudly called his name, and LVN A overheard Kitchen Staff D talking to Resident #1 and walked into the dining room. At 7: 14 a.m. LVN A told LVN B to call 911. LVN B dial 911 and handed the phone to CNA C. Then LVN B returned to the dining room with LVN A. LVN A went to the nurse's station to verify Resident #1's code status and get things to check Resident #1's vitals. LVN B then pushed Resident #1 to the nurse's station after she was unable to get vital signs and he did not respond to a sternal rub. EMS arrived at approximately 7:20 a.m. and left the facility at approximately 7:28 a.m. with CPR in progress. Verbal statements from the staff indicated CNA C said she was asked by LVN B to speak with 911 between 7:10 a.m. and 7:14 a.m. During interviews Kitchen Staff D and Kitchen Staff E said between 6:30 a.m. and 7:00 a.m. they served breakfast. They said that LVN A was in the dining room sitting with residents. They said that LVN B took the smokers out to smoke between 7:00 a.m. and 7:10 a.m. Kitchen Staff D said she went over to Resident #1 to push him to the lobby to help nurses out like she always did while Kitchen Staff E went back into the kitchen. Kitchen Staff D said she could not arouse Resident #1. She said she called his name loudly and LVN A came in the dining room. LVN A said she asked Kitchen Staff D to get LVN B and to call 911. LVN A said EMS arrived at approximately 7:15 a.m. to 7:20 a.m. Resident #2 said Resident #1 was sitting up and talking and joking like he always did. She said she went out with the smokers at 7:00 a.m. for smoke break. She said when she returned from smoking Resident #1 appeared to be sleeping. She said Kitchen Staff D was standing with him, calling his name, and shaking him and LVN A came into the dining room. There was no signature on the typed note. (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 4:50 p.m. a concerned citizen said the facility failed to put life saving measures in place to prevent Resident #1 from dying. They said on [DATE] at about 7:30 a.m. EMS arrived, and a full code resident was sitting in a chair, with nurses standing around not performing CPR. They said EMS was informed by a nurse Resident #1 had been unresponsive since 7:10 a.m. They said Resident #1 was still in the chair and facility staff did not perform CPR to try and save the resident's life. During an interview on [DATE] at 7:47 a.m. the Dietary Manager said she worked [DATE] as a CNA. She said she heard Kitchen Staff D calling for LVN A. She said Kitchen Staff D told her Resident #1's lips were blue when she approached him. The Dietary Manager said the two kitchen aides that worked on [DATE] Kitchen Staff D and Kitchen Staff E She said when she walked up front on the morning of [DATE] someone had brought Resident #1 up to the front and CNA C was on the phone with 911. She said LVN B had the Resident #1 in the Geri-chair and LVN A was behind the nurse's station. During an interview on [DATE] at 7:55 a.m. LVN A said Resident #1 was found in the dining room unconscious. She said she was headed back to the dining room when she heard Kitchen Aide D screaming and calling her name. She said when she went into the dining room Resident #1 was unresponsive, she shook him, did a sternal rub, and did not get a response. LVN A said she asked Kitchen Staff D to get LVN B. She said LVN B called 911. LVN A said she did not notice Resident #1's color or take his pulse. When LVN B arrived, she went to check his code status she did not want to initiate CPR if he was a DNR. She said they did not call for the crash cart. While she was at the nurse's station about 2 minutes, LVN B brought Resident #1 up to the nurse's station. She said just about that time EMS walked in the facility. EMS took Resident #1 out of his chair, put him on the gurney, and initiated CPR. LVN A said Resident #1 was a Full Code. She said Resident #1 did not require assistance with eating, but he had a mechanical soft meat. She said he was sitting at the table by himself with a tray table sit up just for him. She said Breakfast stated about 6:30 a.m. and she left about 6:50 a.m. to go and assist another resident to his room. She said Resident #1 had a history of heart attacks. She said he was in a Geri chair, and she checked the status by looking in her book at the nurse's station. She said the crash cart was located on hall 3, but she never sent for it. She said LVN B checked Resident #1's pulse. LVN A said when EMS arrived it was 4 or 5 EMS workers, and they asked when the last time Resident #1 was responsive. She said she told them it was about 7:10 a.m. She said she was behind the nurse's station when EMS arrived and LVN B handed Resident #1 off to EMS. LVN A said she called the ADON/RN on the way to the nurse's station to let her know what was going on. LVN A said she had been a nurse for less than a year, Resident #1 was her first medical emergency. She said ADON/RN had educated them on doing CPR no matter what. LVN A said she was not sure of the exact time frame because everything appeared to go so fast, but it was at least 5 minutes maybe 10 minutes form the time she saw the resident in the dining room until EMS arrived. During an interview on [DATE] at 8:15 a.m. the Administrator said they had completed a timeline regarding Resident #1. They had investigated the incident and taken statements from staff. She said their investigation did not determine any abuse or neglect, so they had not called the incident into the state. She said they had tried to get hospital records but were unable to do so. She said the EMS company was right down the road less than 5 minutes from the facility and they arrived almost immediately after being called. (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 and observation on [DATE] at 8:17 a.m. LVN B said on [DATE] most residents had finished eating and had left the dining room or been taken to their rooms. She said LVN A left the dining room to take a resident back to his room. She said around 7:00 a.m. there were only two residents left in the ding room, Resident #1, and Resident #2. LVN B said at about 7:00 a.m. someone wanted her to take them out to smoke. She said when she walked outside Resident #1 was drinking his coffee. She said he had a little food on his plate. LVN B said when she came back inside after about 10 minutes, she did not really look at Resident #1. She said she had one resident to push inside, and she had the cigarette box. She said she was at the nurse's station, and she heard Kitchen Staff D yelling for her. LVN B said as she was on her way, she heard LVN A and heard both say come here. She said LVN A called for her, heard her say call 911. LVN B said she called 911 and had CNA C to hold the phone with EMS. She said when she arrived in the dining room Resident # 1 was laid back in his Geri chair, she did see a blue [NAME] to his lips. She said LVN A went to get blood pressure cup and pulse ox. LVN B said she did a sternal rub, she checked Resident #1's pulse at his wrist and neck, and he did not have a pulse. She said she was probably with the resident about 2 minutes after LVN A left. She said LVN A did not return. She said she did not initiate CPR. LVN B said she took Resident #1 to the nurse's station in his Geri chair. LVN B pointed out where the resident was in the dining room which was close to the exit door for the smokers. Observations and interview indicated it was about 100 feet across the dining room to the door and about 5 to 7 feet from the door to the nurse's station. LVN B said the whole process took 5 to 6 minutes. She said no one got the crash cart and she did not request the cart. She said when she got Resident #1 to the nurse's station EMS arrived. LVN B said EMS pulled Resident #1 out of the chair put on gurney and started doing compression right there in the hallway. She said EMS did not ask her any questions, they asked LVN A for a face sheet. LVN B said at school she was taught you did not start CPR until after you verified code status. She said she had been a nurse since [DATE], and this was her first job. She had done CPR but only on a dummy, and Resident #1 was her first code. LVN B said she was in serviced after the incident on [DATE] by ADON/RN who said you start CPR first and then check the code status. During an interview on [DATE] at 8:28 a.m. LVN A said she noted Resident #1's color was off, she did not note anything about his lips being discolored. During an interview on [DATE] at 8:30 a.m., ADON/RN said she came to the facility on [DATE] after the Resident #1 was taken to the hospital. She said she got a call from LVN A on [DATE]. She said her telephone log indicated that call was received at 7:18 a.m. and she was on the phone about two minutes with LVN A. She said when she arrived at the facility, she did in services on emergency procedures and providing CPR. ADON/ RN said she could not say that anyone did anything wrong she just felt that the staff needed education. (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 9:00 a.m. CNA C said she worked at the facility for [AGE] years, and was at the facility on [DATE]. She said she was coming the hall brings something to the dining room. She said she heard Kitchen Staff D yell for LVN A to come to the dining room and run. CNA C said when she made it to the nurse's station LVN B was running to nurse station to call 911. She said LVN B gave the phone to her and told her what to tell dispatch. She said LVN B said they had a resident that was unresponsive, and he was in the dining room. CNA C said while she was still on the phone LVN A came to the Nurses station to see if Resident #1 was full code or DNR. She said LVN A looked on the computer. CNA C said LVN A was on her cell phone talking to ADON/RN. She said she did not know how long LVN A was at the nurse's station, she turned her back while still on the phone with EMS dispatch. She said LVN B brought Resident #1 to the nurse's station still in the Geri chair. CNA C said LVN B asked her to take him to his room while she was still on the phone. CNA C said when Resident #1 was brought to the nurse's station she did not see his color, and no one asked her to get the crash cart. She said after calling EMS they arrived about 5 minutes later. CNA C said it might have been 10 minutes form the time of Kitchen Staff D was screaming to EMS got to the facility. CNA C said LVN A was behind the nurse's station at that point. She said when EMS arrived, LVN B pointed to Resident #1 in the Geri chair. CNA C said EMS asked a few questions, they put Resident #1 on the stretcher, and initiated CPR. She said she did not write a statement; she did not see anyone taking vitals. During an interview and observation on [DATE] at 11:05 a.m. LVN A revealed a book at the nurse's station. Observation of the book showed a couple of pages dated [DATE] with full code residents on the first page and DNR residents on the second page. LVN A said they just updated the list yesterday and that was the book she used to determine if Resident #1 was a full code. She said she did not know how long she remained at the nurse's station after checking but before she could get back to the dining room, LVN B had brought Resident #1 to the nursing station. LVN A said just about that time EMS walked in. She said that she had not taken Resident #1's pulse or checked his mouth to see if there was any food or blockage. During an interview and observation on [DATE] at 11:07 a.m. with the ADON/LVN . The crash cart was located on hall 6 in a storage room. The cart had all the required supplies and on the crash cart was a list of Resident and their code status. The ADON/LVN said the list has always been on the crash cart. The ADON said the AED was located on the wall behind the nurse's station. Observation of the AED showed it was on the wall with the pads right beside it. Also, a battery check of the AED showed it was in working order. During an interview on [DATE] at 11:25 a.m. Resident #2 said she was in the dining room on the morning of [DATE]. She said Resident #1 was his usually joking self. She said they went out to smoke about 7:00 a.m. and he asked for another cup of coffee right before they left. Resident #2 said when they came back inside about ,d+[DATE] minutes later, Resident #1 was sitting in his chair and appeared to be asleep. Resident #2 said she spoke to Resident #1, but he did not speak back. She said it looked like he ate all his food, and sometimes he chokes when he eats, and he made noises in his throat when he ate. She said Kitchen Staff D went over to him and she could not get him to awaken so she started screaming. She said LVN A and LVN B came running. She heard them say something about code status, and they could not find a pulse. She said after a few minutes they took him out of the dining room. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 11:43 a.m. Kitchen Staff D said that she and Kitchen Staff E were in the kitchen with the door closed. She said around 6:50 a.m. they went out to eat their breakfast in the dining room. She said when they first went into the dining room LVN B was there but had gone to get the smoking box for the residents. Then she took them out to smoke. Resident #1 was sitting at the table, and he looked like he was sleeping. She had gone to take him out of the dining room, she said she normally helped the aides get some of the residents out. She said when she had gone over, she could not get Resident #1 to respond, and his color was off. She called his name several times and she guessed LVN A heard her, she did not remember calling her name. Kitchen Staff D said the nurse came and told her to get LVN B. She said LVN B called 911. She did not know what happened after that she said it was 2 or three minutes and they had him up front and she knew the paramedics came and she went back into the kitchen. During a telephone interview on [DATE] at 11:50 a.m. Kitchen Staff E said she and Kitchen Staff D came out of the kitchen around 6:50 a.m. when they arrived in the dining room LVN A got up to take a resident back to their room. She said LVN B went to take the residents out to smoke. She said the whole time they ate their breakfast Resident # 1 appeared asleep. She said she left to go back in the kitchen at about 7:10 a.m. when she finished eating and Kitchen Staff D went to take Resident #1 out of the dining room. Kitchen Staff E said she did not hear any commotion and was only aware of the situation when Kitchen Staff D came back into the kitchen. During an interview on [DATE] at 2:22 p.m. the Administrator and ADON/RN were informed of the concerns about the resident choking and no CPR being provided prior to EMS arrival. They said that EMS company was right down the street, and it did not take them long to arrive at the facility, about 5 minutes. The Administrator said staff acted appropriately, they called 911. The staff did what they were supposed to do. During an interview on [DATE] at 2:55 p.m. LVN B said she did not look in Resident #1's mouth. She said when they went out to smoke, he had a little food on his plate. She said there was a spoon or two of oatmeal and a small piece of biscuit. She did not look at his plate when they returned, or the plate may have been removed. She said the resident did cough on occasion when he ate but she had never seen him choke. During an interview on [DATE] at 3:00 p.m. CNA C said Resident #1 coughed a lot it did not matter if he was eating or not. Sometimes he did cough when he was eating and cleared his throat quite a bit. She said he had done that for a long time, and it was nothing new. During an interview on [DATE] at 3:05 p.m. p.m. CNA F said Resident #1 had a deep cough that would startle you. She said he did cough when he ate occasionally. During an interview on [DATE] at 3:10 p.m. LVN A said she did not look in Resident #1's mouth on the morning of [DATE]. She had gone to get the supplies to complete his vitals. She had told EMS he had been unresponsive 5 to 10 minutes before they arrived. During a telephone interview on [DATE] at 3:15 p.m. with the DON and ADON/RN, LVN A and the Administrator was present. The DON said the nurses saw Resident #1 unresponsive and tried to arise him. She said LVN A went to the nurse's station to get supplies. She said the resident had a history of seizures and she likely thought he had a seizure. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON said she stood behind her staff, the resident was unresponsive, and they called 911. She said that was what they were supposed to do, EMS arrived in about 5 minutes, and they did not have time to initiate CPR. The DON asked LVN A what she thought might have happened with Resident #1. LVN A said she did not know what she thought. LVN A said she was going back to the dining room to check Resident #1's blood sugars because she had not had time to do so prior to breakfast. She said when she found Resident #1 unresponsive, she did not check his blood sugar either. LVN A said it was her first code ever, and her first emergency. She said Resident #1 did have a change in the tone of his skin. She said his skin was usually a light brown but was more of a whiter tone. During an interview on [DATE] at 3:40 p.m. the DON and the Administrator said Resident #1 could have had a seizure. The Administrator said they called 911 and EMS at the facility within 6 minutes. The DON said the nurse did a sternal rub, and that was the first part of an assessment, and then they called 911. The Administrator said their timeline correlated with EMS. During an interview on [DATE] at 4:45 p.m. the ADON/RN said the book that contacted the codes had always been at the nurse's station with code status and the code status were always on the crash cart. They update them every Monday and put them in the book and on the cart. During an interview on ,d+[DATE] at 5:31 p.m. ADON/RN said regarding care plan Resident #1 wanted to be more independent and they allowed him to do so by feeding himself. When he first came to the facility he could hardly move or do anything for himself, but he gotten better. She said he did have days when he required assistance with eating. During a telephone interview on [DATE] at 4:05 p.m. an EMS worker said they were notified by dispatch on the morning of [DATE] there was a resident at the facility in cardiac arrest. The worker said the dispatch said Resident #1 was in the dining room. The EMS worker said when they arrived it was four of them that entered the facility at 7:22 a.m. and were directed to a resident sitting beside the nurse's station in a laid-back chair. They were told this was the resident in distress. The EMS worker said an assessment of Resident #1 showed him to be pulseless and they removed him from the chair and began CPR. He said the nurse told him at 7:10 a.m. Resident #1 was unresponsive. The EMS worker said there had never been a time when they had gone to a facility and nurses were just standing around not providing CPR to a resident in need. The worker said there were at least two people behind the nurse's station and one holding on to Resident #1's chair. The EMS worker said it was over 10 minutes and no CPR was being performed. The EMS worker said when they got the resident to the hospital, they found food in his airway. The facility staff said he had just eaten breakfast but gave no indication he could have choked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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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	Record review of in service dated [DATE] was provided to the investigator on [DATE] at 8:30 a.m. indicated staff were educated on Emergency Procedure policy. Record review of facility emergency procedure/cardiopulmonary resuscitation policy last revised, [DATE]. [The policy statement indicated personnel have completed training on the initiation of CPR and basic life support, including defibrillation, for victims of sudden cardiac arrest. The chances of surviving a sudden cardiac arrest may be increased if CPR is initiated immediately upon collapse. The delivery of shock with the defibrillator plus CPR within 3 to 5 minutes of collapse can further increase chances of survival. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or physicians order not to administer CPR. Emergency procedures indicated if an individual is found unresponsive, briefly check for abnormal or absence of breathing. If sudden cardiac arrest is likely begin CPR. Staff member to activate the emergency response system code and dial 911. Instructed staff member to retrieve the automatic external defibrillator. Verify or instruct the staff member to verify the DNR or code status of the individual. Initiate the basic life support sequence of events, continuous CPR and basic life support until emergency medical personnel arrive.] The Administrator and were notified on [DATE] at 6:10 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided the Immediate Jeopardy template on [DATE] at 6:10 p.m. and a Plan of Removal was requested. The facility's Plan of Removal was accepted on [DATE] at 12:40 p.m. and included: [Plan of Removal: 678: Cardio-Pulmonary Resuscitation (CPR) The facility failed to fully monitor the Resident #1 while he was eating to prevent possible choking. The resident was found unresponsive by a dietary staff. The facility failed to immediately assess the resident or check for a pulse, when finding him unresponsive. They failed to initiate CPR within the first 6 to 16 minutes of finding Resident #1 unresponsive. They failed to follow the facility policy on CPR. 1. Immediate Actions Taken for Those Residents Identified: Action: Resident #1 was noted as unresponsive in the dining room, 911 called, EMTs initiated CPR (not the facility), resident left the home with EMTs in the same condition as noted in the dining room (unresponsive). Resident #1 was later pronounced as deceased outside the nursing home. Person(s) Responsible: Charge Nurse Date: [DATE] 2. How the Facility Identified Other Possibly Effected Residents: Action: Completed a DNR and Full Code audit: Reviewed Physician orders, vs the face sheet, vs the care plan, vs the Out of Hospital DNR (if applicable) to ensure all are matching and correct. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Person(s) Responsible: Director of Clinical Operations, Clinical Resource Nurse, and/or Designee Date: [DATE] Action: Audit staff CPR cards to ensure proper number of certified employees present each shift. Person(s) Responsible: Human Resources, Administrator, and/or Designee Date: [DATE] 3. Measures Put into Place/System Changes to remove the immediacy, and what date these actions occurred: Action: Ensured the crash cart has an updated list of full code and DNR residents. Person(s) Responsible: Administrator and/or Designee Date: [DATE] Action: The facility will be updating their CPR policy to take out: If the resident's DNR status is unclear, CPR will be initiated per the below procedure until it is determined that there is a DNR or a physician's order not to administer CPR. The facility will be updating their CPR policy to now reflect: If the staff assigned to check the resident's code status is unable to verify if the resident is a Full Code or DNR, CPR will be initiated, per the procedure lined out below, until it is determined that there is a DNR in place, a physician's order to stop CPR, and/or the Emergency Medical Technician/Paramedics take control of the event. Person(s) Responsible: Chief Nursing Officer Date: [DATE] Action: Administrator and Director of Nursing educated regarding the Emergency Management Code Procedure Policy and meal supervision expectations by the Director of Regulatory Compliance and meal service supervision (training the trainer). All Nurses educated regarding Emergency Management Code Procedure Policy (Updated on [DATE]) to include the following, in which would be the response in an emergency situation for a full code resident requiring CPR: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. If an individual is found unresponsive, the nurse to first arrive to the resident will briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: The first responding nurse will- Instruct a staff member to activate the emergency response system (code) and call 911. The first responding nurse will- Instruct a staff member to retrieve the automatic external defibrillator. The first responding nurse will- Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic lif [TRUNCATED]