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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015388	A. Building B. Wing	06/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Glen	53 Medical Park Drive East Birmingham, AL 35235

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** Based on record review, interviews, and review of a facility policy titled Cardiopulmonary Resuscitation (CPR) Compression Airway Breathing (CAB), The American Heart Association (AHA) current website for CPR & First Aid Emergency Cardiovascular Care, and the AHA Adult Basic Life Support (ABLS) Algorithm for Health Care Providers the facility failed to initiate CPR in accordance with facility policy and in accordance with the AHA, ABLS for Resident Identifier (RI) #1 on [DATE], when Employee Identifier (EI) #4, a Licensed Practical Nurse (LPN), determined RI #1 was unresponsive and had no palpable pulse upon returning to the facility. On [DATE], RI #1 was transferred by a transport van contracted by the facility to and from a medical appointment. RI #1's spouse and transport van driver stated RI #1 slid onto the van's floor from his/her wheelchair. The van driver informed RI #1's spouse that she needed to pull over and assess RI #1 but was directed by the spouse to continue driving to the facility. The van driver stated while driving she called the facility to alert them what occurred. Upon arrival to the facility, EI #4, LPN responded and observed RI #1 lying on his/her back with his/her legs between driver seat and passenger seat. EI #4 stated he assessed RI #1 and found him/her to be unresponsive and without a carotid pulse. EI #4 stated he provided sternal rub but failed to initiate CPR, activate Emergency Medical System (EMS), or summon additional assistance from facility staff. EI #4 stated he instructed the van's driver to transport RI #1 to the emergency room across the street instead of immediately performing CPR. Upon arrival at the emergency room (ER) RI #1 was found to be apneic and without a pulse. The ER staff performed Advanced Cardiac Life Support (ACLS) for twenty (20) minutes but was unsuccessful in reviving RI #1. The ER pronounced the death of RI #1 at 6:13 PM. This deficient practice placed RI #1, one of three sampled residents reviewed for the provision of CPR, in immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment or death. This had the potential to affect 18 full code residents of 26 residents under the care of EI #4 on [DATE]. On [DATE] at 3:37 PM, EI #1, the facility Administrator and EI # 2, the Director of Nursing (DON) were given a copy of the Immediate Jeopardy (IJ) template and notified of the findings of substandard quality of care at the IJ level in the area of Quality of Life, at F678-Cardio-Pulmonary Resuscitation (CPR). The immediate jeopardy began on [DATE] and continued until [DATE] when the facility implemented corrective actions to address the identified deficient practice, including ongoing monitoring; thus, immediate jeopardy past noncompliance was cited. (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	Findings include: On [DATE] the State Survey Agency received an Online Incident Reporting System from East Glen Nursing Facility at 4:11 PM. East Glen submitted to the Alabama State Survey Agency an allegation labeled as other. The report identified, Resident left the facility with (spouse) in transport van, for a follow up appointment transported by (name) transportation. During the return trip driver reports resident slid out of chair. Upon return to facility resident was assessed in the van and noted to be unresponsive and without pulse. Nurse prompted (spouse) and driver to take resident to the emergency room . The facility timeline dated [DATE] for RI #1 identified the following: Approximately 2:45 pm (RI #1) left facility with (Name) Transport, accompanied by (his/her) spouse to go to a scheduled follow-up appointment . Approximately 5:36 pm (Name) Transport service called (EI #3, Director of Admissions) and informed her that RI #1 had slid out of (his/her) chair and they were pulling up to East Glen. Approximately 5:37 pm (EI #4) received phone call from (Name) Transport letting him know (RI #1) was unresponsive and could not wake (him/her) up and they were outside at front. (EI #4) immediately gathered staff and went to assess (RI #1). (RI #1) was found lying in the floor of van . (EI #4) went in the van and checked pulse. After not finding a pulse (EI #4) instructed the driver transport (RI #1) across the street to (Name of hospital) for evaluation . The facility's policy titled Cardiopulmonary Resuscitation (CPR)/Compression Airway Breathing (CAB), dated 03/2016, documented: PURPOSE: To circulate oxygenated blood through the body until advanced medical support arrives. STANDARD: CPR is initiated when indicated on residents who do not have DNR (Do Not Resuscitate) orders. PROCESS: (Some of these actions may occur simultaneously and / or by persons other than the first person responding to the scene) 1. Assess the resident's breathing and pulse. 2. Activate EMS system-call 911. 3. Begin compressions at a rate of 100 to 120 per minute at a depth of approximately 2 inches. Avoid excessive chest compressions depths of more than 2 inches. 4. Give 2 rescue breaths after 30 compressions. 5. Notify physicians/family/sponsor. 6. Continue compressions/breath cycle until EMS arrives or resident regains consciousness . The American Heart Association (AHA) Adult Basic Life Support (ABLS) Algorithm for Health Care Providers, dated 2020, documents the following sequence of response should be initiated in the event Health Care Providers respond to a person in need of CPR and EMS: . Verify scene safety. Check for responsiveness. Shout for nearby help. Activate emergency (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	response system via mobile device (if appropriate). Get . emergency equipment (or send someone to do so). Look for no breathing or only gasping and check pulse (simultaneously). No breathing or only gasping, pulse not felt . By this time in all scenarios, emergency response system or backup is activated . and emergency equipment are retrieved, or someone is retrieving them. Start CPR Perform cycles of 30 compressions and 2 breaths . Check . (for a pulse if no AED). Resume CPR immediately . Continue until ALS (advanced life support) providers take over or victim starts to move. The AHA current website for CPR & First Aid Emergency Cardiovascular Care documents Science-based Guidelines . All recommendations below are based on the AHA Guidelines Update for CPR and Emergency Cardiovascular Care (ECC) . CPR . is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances of survival after cardiac arrest . RI #1 was admitted on [DATE] with diagnoses including: Metabolic Encephalopathy, Altered Mental Status, and Malignant Neoplasm. A review of RI #1's Physician Orders for the month of [DATE] revealed an order dated [DATE] for FULL CODE STATUS. A review of the facility's NON-WITNESS STATEMENT . dated [DATE] completed by EI #4 (LPN) identified that . At 5:46 PM the . driver called my personal phone and stated the Resident was unresponsive and not moving, and she was parked in the front of the facility. I then called both of my CNAs .and told them we have an emergency .I then went into the van to assess the resident. (He/She) was lying on (his/her) back with .legs in between the driver and passenger seat . Resident was pale in color .I checked the carotid for pulse and couldn't find one a sternal rub was performed also; I then instructed the driver to take (him/her) across the street to the Hospital . An interview was conducted on [DATE] at 10:30 AM with RI #1's spouse who reported he/she accompanied RI #1 to an appointment. RI #1's transportation was scheduled by the facility with a contracted company for non-emergency van transport. After the appointment and during the transport back to the facility he/she (spouse) was sitting behind RI #1. The resident's spouse said halfway to East Glen RI #1 slid out of the wheelchair onto the floor of the minivan. The spouse said when they arrived at the facility things happened quite fast. He/she continued to say several staff came to the van and a nurse assessed RI #1, but the nurse did not do anything and said take him/her to the ER. RI #1's spouse said the nurse did not perform CPR. RI #1's spouse was asked, did he/she agree that RI #1 needed to be transported to the ER in the van. He/she replied that he/she did not but what else was he/she going to do; it was out of his/her hands and sounded like the appropriate thing to do. RI #1's spouse said it took three to four minutes to transport RI #1 to ER from facility. An interview was conducted on [DATE] at 11:55 AM with the contracted van transport driver. The van driver reported when she picked up RI #1 from the doctor's appointment, he/she looked asleep and tired. The van driver said during the return trip RI #1 did not say anything and RI #1 kept sliding down in the chair. The van driver said RI #1 slid out of the wheelchair to the van's floor before arriving at the facility. The van driver said when they arrived at the facility it took staff about five to ten minutes to respond to their arrival. The van driver said staff got into the van and just stood there looking. The nurse said RI #1 was pale and instructed her to take RI #1 to the hospital. The van driver said she took RI #1 to the ER. When she arrived at the ER several staff came out and a nurse started CPR. The van driver said then ER staff brought a stretcher, removed RI #1 from the van, and continued CPR. The van driver stated that she was CPR certified and thought EI #4 should have at least entered the van and started CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with EI #4 (LPN) was conducted on [DATE] at 1:00 PM. EI #4 was asked how he knew when to start CPR/BLS (Basic Life Support) for a resident. EI #4 replied, he would check for carotid pulse, rise and fall of chest, whether the skin color was normal, talked with patient to make sure patient could not respond. EI #4 said, he would check the airway and pulse, and if absent CPR would definitely be started. EI #4 was asked, what happened when RI #1 arrived at the facility in the transport van. EI #4 said the van driver called to report she could not wake RI #1 and RI #1 was not moving. EI #4 said he immediately summoned two CNAs, went out to the van, and then got into the van to assess RI #1. EI #4 said he performed a sternal rub with no response and was unable to palpate the carotid pulse. EI #4 said he told the van driver that RI #1 was in very critical condition, and she needed to get RI #1 to the hospital. EI #4 stated he did not know how long RI #1 had been non-responsive. EI #4 stated in an emergency response his role was to take the crash cart and perform CPR. EI #4 was asked, according to BLS and facility policy, what actions should have been taken based on his assessment. EI #4 stated, when breathing and pulse were not present, CPR should have been initiated. EI #4 stated he did not activate EMS and made the decision to send RI #1 to the ER. An interview was conducted on [DATE] at 6:10 PM with EI #8, CNA. EI #8 said EI #4 said he needed her because RI #1 was not responding. EI #8 said they went to the van. EI #8 said RI #1 was lying flat on his/her back wedged between the driver seat and the passenger seat. EI #8 stated the van driver said, (she/he) been down there for a while. EI #8 said EI #4 climbed into the van, assessed RI #1, and realized he/she did not have a pulse. EI #8 said RI #1 was very pale as white as a piece of paper. EI #8 said EI #4 told the van driver to take the resident to the hospital immediately and said RI #1 did not have a pulse. EI #8 said the driver asked where was the hospital; EI #8 and EI #4 pointed across the street. An interview was conducted on [DATE] at 3:25 PM with the emergency room physician who provided care to RI #1. The emergency room physician stated RI #1 arrived at the ER near 6:00 PM and did not have a pulse. He stated that the ER staff performed 20-30 minutes of ACLS according to protocol before death was pronounced. The ER physician stated when a resident was found to be pulseless nursing staff should immediately initiate CPR. An interview was conducted on [DATE] at 1:00 PM with EI #2 (Director of Nursing). EI #2 stated the code status for all residents was documented on the front of the resident's chart and in the Electronic Health Record (EHR). EI #2 stated the steps in determining if a resident requires CPR was to check code status, once identified if the resident was a full code status, then CPR would be initiated by assessing breathing and pulse. EI #2 stated when a resident was without a pulse, the nurse should initiate CPR and activate EMS. EI #2 stated EI #4 did not initiate CPR according to facility policy. EI #2 stated it was not standard policy and procedure to send a resident to ER without initiating CPR. EI #2 stated all licensed nurses were CPR certified. An interview was conducted on [DATE] at 11:45AM with EI #1, Administrator who stated all licensed staff (LPN's and RN's) were trained on BLS through AHA and they know what to do in emergency. EI #1 stated she was told RI #1 went out to a medical appointment and on the way back to the facility he/she slid out of the wheelchair. EI #1 stated the van driver called the facility and notified the nurse RI #1 slid out of the chair. EI #1 stated when the van arrived, RI #1 was on the floor of van according to the nurse's statement. EI #1 stated EI #4, LPN assessed RI #1 and immediately sent him/her to the emergency room across the street. EI #1 stated according to facility policy, staff should have verified code status and initiated CPR. EI #1 stated that a resident requiring emergency care prior to the arrival of emergency medical (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	personnel should receive basic life support, including CPR. EI #1 stated on [DATE] RI #1 was assessed by EI #4 to be pulseless and was not provided CPR by EI #4 nor was emergency services contacted. EI #4 instructed the van driver to take RI #1 to the ER by non-emergent transport. This deficient practice was cited as a result of the investigation of complaint/report number AL00044244 ** The facility took the following immediate action to correct the deficient practice; thus, past non-compliance was cited: 1) Reported the incident to ADPH Online Reporting System on [DATE] and investigation completed. 2) Notified Medical Director, audit conducted on all resident's code status and care plans on [DATE]. 3) Terminated contract with transport company on [DATE]. 4) Held a QA held and QAPI (Quality .) on [DATE]. 5) On [DATE] EI #4 was provided 1:1 education/in-servicing on the facility CPR policy and code status. 6) Completed in-servicing for all licensed staff on Code Status and performance of CPR on [DATE]. 7) Completed Mock Codes on [DATE] and [DATE]. 8) Completed audit for licensed staff to verify CPR on [DATE]. 9) DON monitoring all unusual occurrences beginning on [DATE].