STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225584	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Health Center	146 Park Avenue Arlington, MA 02174

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 0726 Level of Harm - Minimal harm or potential for actual harm 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was found unresponsive by staff, and required staff to initiate a Code Blue, the Facility failed to ensure that Licensed Nursing Staff were competent in the process of calling and responding in the event of a Code Blue situation. Findings include:Review of the Facility Policy titled, Emergency Procedure, Cardiopulmonary Resuscitation (CPR), dated as last revised 02/2018, indicated that personnel have completed training on the initiation of CPR and Basic Life Support (BLS).The Policy further indicated that if an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR;-Instruct a staff member to activate the emergency response system (CODE BLUE) and call 911;-Instruct a member to retrieve that automatic external defibrillator;-Verify or instruct a staff member to verify the Do Not Resuscitate (DNR) or code status of the individual; and-Initiate the BLS sequence of events, C-A-B (chest compressions, airway, breathing).According to the Board of Registration in Nursing, 244 CMR9:00: Standards of Conduct, competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a Nurse Licensed by the Board and for the delivery of safe Nursing care in accordance with accepted Standards of Practice.Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.Resident #1 was admitted to the Facility in [DATE], diagnoses included Chronic Obstructive Pulmonary Disease (COPD, airflow is blocked and makes it difficult to breath), End Stage Renal Disease (ESRD, kidneys no longer function to rid the body of waste) requiring hemodialysis (medical procedure that cleans the blood when kidneys fail), and recent amputation of a right below the knee amputation (BKA).During an interview on [DATE] at 1:47 P.M., Nurse #1 said that on [DATE] at 6:30 A.M., he went into Resident #1's room, obtained his/her Capillary Blood Sugar (CBG), result was 123 and said he/she appeared fine. Nurse #1 said he went to the medication cart (at the Nurses Station), recorded the CBG (6:44 A.M.), made a phone call to the Dialysis Center for a time related to Resident #1"s treatment, and then obtained morning medication for Resident #1.Nurse #1 said upon return to Resident #1's room, around 6:45 A.M, he observed that he/she was in his/her wheelchair and was unresponsive. Nurse #1 said he called his/her name multiple times with no response, performed a sternal rub without effect, and that Resident #1 was turning a bluish color.Nurse #1 said he then called out for help, that CNA #1 and CNA #2 responded, they lowered Resident #1 to the floor, and he began chest compressions. Nurse #1 said he called 911/ Emergency Medical Services (EMS) from his personal mobile phone, applied the AED pads, with no shock advised, and re-initiated chest compressions until EMS arrived. Nurse #1 said that he does not recall who retrieved the Code Cart or the AED.Nurse #1 said that he did not overhead page a Code Blue or delegate the task to one of the CNA's to call a Code Blue. Nurse #1 said that this was his first actual Code Blue event and said that he should have had someone overhead page a Code Blue so other nursing staff could have responded in the emergent situation.During a telephone interview (which included a review of her written statement) on [DATE] at 12:35 P.M., CNA #1 said Resident #1 was on her assignment for the 11:00 P.M. - 7:00 A.M. shift on [DATE] into [DATE]. CNA #1 said around 6:00 A.M. Resident #1 had put his/her call bell on and asked to get into his/her wheelchair. CNA #1 said when she left Resident #1's room he/she appeared to be fine, then she left the unit and went down to the basement to get some briefs.CNA #1 said upon return to the unit, while at the nurse's station Nurse #1 said to her that Resident #1 did not appear to be breathing so she went to his/her room with Nurse #1. CNA #1 said that Nurse #1 left the room to get the Code Cart and AED while she stayed with Resident #1 and when Nurse #1 returned, they placed him/her onto the floor, applied the AED pads, called 911 and Nurse #1 began compression. CNA #1 said she does not recall hearing a Code Blue being paged overhead and said she was not asked to overhead page a Code Blue by Nurse #1.During a telephone interview on [DATE] at 9:22 A.M., CNA #2 said that on [DATE] she was working on the second floor (Resident #1's unit) that shift, however Resident #1 was not on her assignment. CNA #2 said that she heard Nurse #1 yell her name for help and said when she entered the room, Resident #1 was still sitting in his/her wheelchair, and she helped CNA #1 and Nurse #1 transfer and lower Resident #1 onto the floor. CNA #2 said she was not asked to call a Code Blue and does not remember hearing a Code Blue being paged overhead. CNA #2 said when a Code Blue is called other staff come and help.During an interview on [DATE] at 12:12 P.M., CNA #4 said that he was working on the third floor for the 11:00 P.M.