STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREST HAVEN NURSING AND REHABILITATION CENTER	**4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210**

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 **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** C#: NJ 2 Based on observation, interviews, medical record review, and review of other pertinent facility documentation on [DATE] and [DATE], it was determined that the facility staff failed to initiate and administer Basic Life Support /Cardiopulmonary Resuscitation (CPR) timely and appropriately to 1 of 3 sampled residents (Resident #2) reviewed for CPR. The facility also failed to follow their own policy titled Code Blue-Medical Emergency, when on [DATE], Resident #2 was found unresponsive with no apical or carotid pulse at 4:40 p.m., in the resident's bathroom by the Registered Nurse (RN) Supervisor and the Certified Nursing Assistant (CNA #1). Instead of initiating CPR and calling a code blue at this time, the RN Supervisor left Resident #2 with CNA #1 and went to get help. The RN Supervisor walked down the hallway and went to the nurse's station, where she announced over the intercom for the Licensed Practical Nurse (LPN) to come to the nurses' station because there was an emergency. The RN Supervisor then encountered a second Certified Nursing Assistant (CNA #2) and the LPN. The RN Supervisor then told CNA #2 to take the crash cart to Resident #2's room and directed the LPN to perform CPR on Resident #2. The RN Supervisor proceeded to call 911, but could not get through to the number and contacted the Security desk to dial the number. The LPN and CNA #2 arrived at Resident #2's room with the crash cart at approximately 4:43 p.m., and the LPN initiated CPR. However; three minutes has passed since Resident #2 was found unresponsive at 4:40 p.m. The RN Supervisor returned to Resident #2's room at 4:45 p.m., but the RN Supervisor failed to announce a Code Blue response throughout the facility so that other licensed staff members could arrive to Resident #2's room and provide assistance. The Paramedics arrived at Resident # 2's side at 4:55 p.m. and found Resident #2 unconscious, unresponsive, and pulseless, and pronounced Resident #2 deceased at 4:57 p.m. This failure to administer CPR immediately and timely to Resident #2, who had documented resuscitation orders and an active Advanced Directive for resuscitation, resulted in an immediate jeopardy (IJ) situation and had the likelihood to affect all other residents in the facility who had an Advance Directive and resuscitation orders. The surveyor identified the IJ on [DATE] day 2 of the survey. The surveyor discussed the findings with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), on the same day at 2:25 p.m. The IJ ran from [DATE] through [DATE], when the facility began educating the RN Supervisor and all licensed staff on their policy and procedures. The Administrator presented an acceptable Removal Plan on [DATE] at 2:52 p.m., to the surveyor, which included the initiation of in-services for all licensed staff on the facility's policy and CPR administration. The facility had initiated the removal plan. A revisit was done on [DATE] to ensure the removal plan was implemented. This deficient practice was evidenced by the following: Review of the medical record (MR) were as follows: 1. According to the Face Sheet, Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Face Sheet also showed that Resident #2 was a Full Code. According to the Minimum Data Set (MDS), an assessment tool dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of ,[DATE], which indicated the Resident was cognitively intact. The MDS documentation included that Resident #2 required staff assistance with all Activities of Daily Living (ADLs). According to the Facility Reportable Event (FRE) (a document used by facilities when reporting to the New Jersey Department of Health) dated [DATE], Resident # 2's neighbor (the Resident in the room next to Resident 2's room) reported to the Security Guard, that he/she heard a fall in the bathroom and Resident #2 calling for help. The Security Guard located the RN Supervisor and relayed the information to the RN Supervisor, who responded to Resident # 2's room with CNA #1. Also, the FRE revealed that Resident #2 was found lying face down in the bathroom, by the RN Supervisor and CNA #1. Further review of the FRE revealed that the RN Supervisor assessed Resident #2, who had no respirations, and no apical or carotid pulse. Also, after performing the assessment on Resident #2, which revealed the Resident had no respirations, and no apical and carotid pulse, the RN Supervisor left the room without initiating resuscitation for Resident #2, and CNA #1 remained with the Resident. The FRE also revealed that the RN Supervisor went to the nurses' station and called an LPN to start CPR on (Resident #2) while she called 911 On [DATE] the surveyor reviewed the Progress Notes (PN) dated [DATE] at 8:30 p.m., written by the RN Supervisor, which revealed that at approximately 4:40 p.m., the RN Supervisor was paged due to Resident #2 who had fallen in the bathroom. The PN revealed the RN Supervisor and CNA #1 found Resident #2 face down in the BR (bathroom), and the Resident face was purple and cold, and (he/she) was unresponsive Also, the PN revealed that CPR was started; 911 was called at 4:43 p.m. Resident # 2's PN also indicated that the AED (Automated External Defibrillator) was used, but no shock was recommended. Further review of the PN revealed the Paramedics arrived at 4:49 p.m., and there was no HR (heart rate) on their EKG reading, and (Resident # 2's) eyes were fixed and dilated. A review of a Care Plan (CP) revised [DATE], included Resident #2 was a full code, and has limited physical mobility, related to [MEDICAL CONDITION], a history of muscle weakness and a history of hip and knee surgery. A review of a Physician order [REDACTED].#2 had an Advanced Directives and was a Full Code. Review of an Advance Directives for Health Care (a legal document in which an individual indicates the actions that should be taken for their health if they are unable to decide for themselves) dated [DATE], for Resident #2 and signed by Resident # 2's power of attorney (POA), revealed if the Resident should suffer a [MEDICAL CONDITION] Resident #2 direct that CPR is provided to preserve the Resident's life. Review of the Resident Accident/ Incident Report (RA/IR) dated [DATE] and untimed, written by the RN Supervisor, showed Resident #2 had fallen while walking or standing. Under Summary and Conclusion, showed the Resident had a possible sudden death event. Under Corrective Action Plan revealed Inservice Nursing Staff- Code Blue/ Recitation/ CPR policy/ procedure The surveyor reviewed a facility's document titled Voluntary Statement Form (VSF), dated [DATE] at 6:38 p.m., written by the LPN. The LPN documented that the RN Supervisor paged overhead for her that we have an emergency, I need you. The LPN explained that she exited the restroom and observed CNA #2 with the crash cart. The LPN continued to explain that the RN Supervisor stated that Resident #2 was in the bathroom unresponsive. CNA #2 and the LPN ran down the hallway with the crash cart and entered the Resident's room. The LPN also documented that Resident #2 was observed lying on his/ her back next to the toilet. Resident #2 was unresponsive with no pulse, and I initiated CPR. The surveyor reviewed a second VSF, dated [DATE], at 9:00 p.m., written by the RN Supervisor. The RN Supervisor documented that the Security told her that Resident #2 fell in the bathroom. The RN Supervisor explained that she called CNA #1 to assist her with Resident #2, and when they walked into the bathroom, they found Resident #2 lying face down on the floor. Resident # 2's face was purple and cold, and the Resident was unresponsive. The RN Supervisor and CNA #1 log rolled Resident #2 onto her back for the RN Supervisor to assess the Resident. The RN Supervisor documented that Resident #2 had no carotid or apical pulse, and no respirations. The RN Supervisor further documented I called to the other LPN to start CPR while I called 911 . A review of the Paramedics report dated [DATE] at 11:34 a.m., and electronically signed by the Physician, revealed that on [DATE] at 4:47 p.m., the Paramedics were dispatch to the facility, due to [MEDICAL CONDITION] -Resuscitation in Progress. The report also revealed that the Paramedics arrived at Resident # 2's side at 4:55 p.m. and found Resident #2 unconscious, unresponsive, pulseless,

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 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) apneic, asystolic, and (he/she) had lividity to the small of (his/her) back. Also, the report revealed that Resident # 2's pupils were dilated and not reactive. The Physician was notified, Resident #2 was pronounced deceased at 4:57 p.m. A review of the RN Supervisor employee file revealed that the RN Supervisor had current certification in CPR, with an expiration date of [DATE]. During a phone interview with the surveyor on [DATE] at 12:12 p.m., the LPN stated she was in the restroom and heard the RN Supervisor paging her overhead, I need your assistance. As she walked out of the restroom, she saw CNA #2 with the crash cart and the RN Supervisor, who then told the LPN that Resident #2 was unresponsive. The LPN stated that she and CNA #2 ran down the hallway towards Resident # 2's room and saw the Resident lying on her back without a pulse and was unresponsive. The LPN started doing chest compressions. The LPN further explained while doing chest compressions for Resident #2, the RN Supervisor called the room over the intercom system and asked the LPN if the RN Supervisor should come back to Resident 2's room. The LPN told the RN Supervisor that she should come back to Resident # 2's room. The LPN stated the RN Supervisor came back to Resident #2's room and took over chest compressions, and asked the LPN to get the Ambu bag off of the crash cart; the LPN gave the Ambu bag to the RN Supervisor. Then the RN Supervisor told her to go and make copies of the Resident's documents for the EMTs (Emergency Medical Technicians) responders. During an interview with the surveyor on [DATE] at 3:20 p.m., CNA #1 stated the RN Supervisor called her name and said to meet her in Resident # 2's room. The CNA stated that she went into Resident # 2's room with the RN Supervisor behind her. Resident #2 was in the bathroom face down, and she called Resident 2's name, but the Resident did not respond. CNA #1 explained that she told the RN Supervisor we have to turn Resident #2 over onto her back because the Resident's face was planted onto the ground, and Resident #2 was not going to be able to breathe. The RN Supervisor and CNA #1 then turn Resident #2 over, and they were still no response. CNA #1 also explained that the RN Supervisor checked Resident # 2's pulse and heart with a stethoscope, but the RN Supervisor did not do CPR, for Resident #2. During a phone interview on [DATE] at 9:20 a.m., the RN Supervisor stated herself and CNA #1 responded to Resident # 2's room and found Resident #2 face down in the bathroom, they both turned the Resident over onto his/her back, the Resident did not have a pulse and was not breathing. The RN Supervisor explained that she left CNA #1 in the bathroom with Resident #2 and ran to the nurses' station to call 911 and get help. The RN Supervisor indicated that she found the LPN, who was coming out of the bathroom, and asked the LPN to go to Resident # 2's room and initiate CPR. The RN Supervisor stated she did not call a Code Blue. When asked by the surveyor why she did not call a Code Blue or have a Code Blue called the RN Supervisor stated, I did not think of it. The RN Supervisor indicated she already knew that Resident #2 was a full code; therefore, she did not need to check the Resident's MR to verify his/her code status. The RN Supervisor also stated, I thought I could run to the phone and call 911 and come back. I thought it would be quick. Also, the RN Supervisor stated, I should have started CPR first and have (CNA #1) call 911 and call the other nurse. During an interview on [DATE] at 12:10 p.m., the DON stated the RN Supervisor is responsible for making decisions during a code. The DON also explained the RN Supervisor should have had CNA #1 called the code blue and get the LPN. The DON stated that the RN Supervisor left the room, called the code, and told the LPN to do CPR. The RN Supervisor should have stayed with Resident #2 and instituted CPR. The RN Supervisor did not follow the facility's policy. The surveyor requested to review the video camera recording for [DATE]. The video recording was reviewed on [DATE] at 10:26 a.m., in the presence of the ADON and security guard. The video recording showed the RN Supervisor entered the Security's office at 4:35 p.m. The RN Supervisor came out of the security guard's office at 4:36 p.m., went to the double door leading to the outside of the building, and returned with a pharmacy bag. At 4:38 p.m., the video recording showed The RN Supervisor walking towards the nurses' station. The video recording showed the RN Supervisor speaking with CNA #1 at 4:39 p.m., and they both walked down the hallway towards Resident # 2's room, with the RN Supervisor rolling an electronic blood pressure machine. The recording also showed the RN Supervisor and CNA #1 entered Resident # 2's room at 4:40 p.m., with the CNA in the lead. Further review of the video recording showed the RN Supervisor came out of Resident # 2's room at 4:41 p.m. and walked towards the nurses' station. The RN Supervisor arrived at the nurses' station at 4:42 p.m., and CNA #2 walked towards the nurses' station and spoke with the RN Supervisor. The LPN was observed walking by the nurses' station talking with the RN Supervisor, who was also on the phone at that time. The LPN and CNA #2, who had the crash cart ran down the hallway towards Resident # 2's room. The LPN and CNA #2 entered Resident # 2's room at 4:43 p.m., with the LPN in the lead. A review of the facility's policy titled Code Blue- Medical Emergency, dated ,[DATE], included but was not limited to the following: Under Purpose: To ensure cardiopulmonary resuscitation is initiated on any resident without a pulse or respiration, and who does not have a Do Not Resuscitate order. Under #3. Determining Code Status a. If a resident is found to be: i. Anemic (not breathing) ii. Useless iii. Does not have other signs of clinical death such as: 1. Rigor mortis 2. Fixed pupils Under #7. Roles in a code: a. Team Leader: Supervisor or RN who is CPR certified will coordinate the sequence of the code and initiate code record. b. Airway Manager: Responsible for use of the Ambu-bag. c. External Chest Compressor: A staff member who is CPR certified. d. Recorder: RN or LPN. e. Runner a licensed staff member who is responsible for: i. Checking the Resident's chart for code status. ii. Notifying the receptionist or Security of the code. iii. Calling 911. The Immediate Jeopardy (IJ) to Resident #2's health and well-being began on [DATE] when Resident #2 was found pulseless and unresponsive and delayed, and incorrect CPR was administered and ended on [DATE] when the facility started in-servicing the RN Supervisor and its other licensed staff. The RN Supervisor did not follow the policy, as mentioned above. The Administrator presented a Removal Plan, which was accepted by the surveyor on [DATE] at 2:52 p.m. A revisit was done on [DATE] to ensure the removal plan was implemented as follows: Actions taken to the situation identified: 1. Corrective action was taken on [DATE], by inservicing the nurse involved and initiating training of the licensed nurses on implementing the ABC's (airway breathing circulation) during a Code Blue Response in Long Term Care. Prompt initiation of CPR and CPR procedures Crash cart review AED review Demonstration of AED application Demonstration of proper chest compression and hand placement Proper oxygen administration Airway management Responsibilities of Code Facilitator Post-Code Documentation 2. All licensed nurses will participate in required education at least quarterly. The facility will conduct a Code Blue Drill and education monthly. Outcome will be reviewed with the Quality Improvement Committee. The education will be updated and adapted as needed. N.J.A.C: 8:,[DATE].4(c) 1 N.J.A.C: 8:,[DATE].1(a)