STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375570	A. BUILDING _____ B. WING _____	**09/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCEL AT CRYSTAL PARK	**315 SW 80TH STREET OKLAHOMA CITY, OK 73139**

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** On [DATE] at 4:10 p.m., an Immediate Jeopardy (IJ) situation was verified with the Oklahoma State Department of Health regarding the facility's failure to provide cardiopulmonary resuscitation (CPR) to a resident who had no pulse and no blood pressure and who was a full code. At 4:25 p.m., the facility administrator and the DON were informed of the IJ situation related to the facility's failure to provide CPR for a resident. A plan of removal for the IJ situation was requested. At 5:37 p.m., the administrator provided the survey team with an acceptable written plan of removal. The facility's plan of removal, dated [DATE], documented the following: .Plan of Removal . -Inservice initiated with Licensed nurse [DATE] and completed [DATE]; over Change in Condition, CPR policy/procedure to include immediate initiation of CPR if Full Code, code status on hand, assessment of patient. This training included notification of change in condition to physician immediately upon identification of change. Nurses were educated in regard to identifying changes in condition. Facility expectation is based on the clinical situation of resident the nurse would notify the physician, director of nursing and call 911. -Mock Code Blue completed by DON on [DATE]. -Audit of crash cart completed [DATE] and will continue daily monitoring. - Audit of CPR certifications for licensed nurses completed [DATE] , and nurses scheduled for CPR certification training ,[DATE] and [DATE]. CPR and AED competencies to be completed with all current nurses by 5pm on [DATE]. - All new hired nurses will have CPR and AED training during orientation, with competencies completed and documentation of current CPR certification within 30 days of hire. -Social Services will ensure Advance Directive Acknowledgements are completed with new patients upon admission, order is obtained for code status and documentation is scanned into patient's record as indicated. - All new admits will be reviewed for code status and corresponding documents as indicated during daily clinical meeting and follow up completed as needed. -Any CODE conducted will be reviewed for any issues and corrective action taken as needed. -QAPI will review for any issues with CODE's or Code status at least monthly and make any revisions to the plan . A review of the facility's audit forms and training logs documented the facility had completed the audits and trainings by [DATE] at 2:45 p.m. On [DATE] at 5:45 p.m., the administrator was informed the IJ had been removed as of [DATE] at 2:45 p.m. The deficient practice remained at a level of actual harm, isolated. Based on record review and interview, it was determined the facility failed to provide CPR for one (#1) of two sampled residents who had no pulse and no blood pressure and was designated as a full code. This resulted in an IJ situation. Findings: A facility policy and procedure entitled Cardiopulmonary Resuscitation (CPR): Basic Life Support (BLS)/ Hands-Only CPR, dated [DATE], documented 1. The goal of CPR is to try to maintain life until the emergency medical response team arrives to deliver Advanced Life Support (ALS) 2. If an individual is found unresponsive by an employee of the community the employee will initiate CPR unless: a. It is known that a Do Not Resuscitate order exists for the resident; . Resident #1 had [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The resident's medical record documented the resident had a full code status. A nurse's note, date [DATE] at 4:36 p.m., documented, Late Entry: [DATE]: Reported unresponsive after shaking shoulder by (name deleted), CNA. Pallor noted upon entry. Carotid & radial not palpable. Ext. cool to touch. No visible resp. No audible resp. No reading on pulse ox. Jaw slightly rigid & mouth open. Tongue cyanotic. 2nd assessment by (name deleted), RN w/ same findings. Mod amt dark tarry stool & straw colored urine. (Emergency medical services name deleted) called. 2 person CPR initiated w/ (name deleted), RN until (emergeency medical services name deleted) there to relieve. (Emergency medical services name deleted) performed CPR for 20 minutes and called @ 0820. Funeral home, wife and MD notified @ approx 0900 . An OSDH Incident Report Form Final, received [DATE], documented .At the change of shift LPN (name deleted), the 11:00 p.m. to 7:00 a.m. charge nurse was providing the change-of-shift report to the oncoming 7:00 a.m. to 3:00 p.m. charge nurse, (name deleted), RN and informed RN (name deleted) of a possible change in condition of Resident (name deleted). LPN (name deleted) was informed of the protocol in such change of condition scenarios. LPN (name deleted) assessed Resident (name deleted) and noted him to be without vital signs. CPR was initiated and (emergency medical services name deleted) was called, arrived and took over CPR efforts. (Emergency medical services name deleted) declared the resident deceased . The family and physician were notified. Upon becoming aware of the situation, the facility Director of Nursing, (name deleted), initiated an investigation and suspended LPN (name deleted) pending investigation DON (name deleted) initiated an investigation, which included interviewing the nursing personnel involved in the care of Resident (name deleted) on [DATE], including (name deleted), LPN, (name deleted), RN, (name deleted), RN and (name deleted), CNA. Such interviews indicated that at or about 5:00 a.m. on [DATE], CNA (name deleted) discovered that Resident (name deleted) was pale, nonresponsive and appeared, to not be breathing. CNA (name deleted) summoned LPN (name deleted) who assessed the resident and found him non-responsive. She was unable to obtain a reading using pulse oximeter or blood pressure. LPN (name deleted) summoned another charge nurse on duty, (name deleted), RN, who also evaluated the resident and found him to be non-responsive, cool to the touch, and having cyanosis. Based on the foregoing assessments, LPN (name deleted) apparently concluded that the resident was deceased . .As mentioned above, during the shift change she informed oncoming charge nurse (name deleted), RN of Resident (name deleted) change in condition. Based on RN (name deleted) response, LPN (name deleted) notified Dr. (physician's name deleted), the resident's attending physician, and then returned to the resident's room and initiated CPR with RN (name deleted). (Emergency medical service name deleted) was summoned at approximately 7:30 a.m. and upon arrival continued CPR until such time as (emergency medical service name deleted) declared the resident was deceased . LPN (name deleted) notified the family and the designated funeral home. The resident's body was removed from the facility at approximately 9:00 a.m . .After investigation it was noted that the patient's current code status was in the EHR as a full code. The facility determined that (name deleted), LPN an (name deleted), RN failed to follow the facility's policies regarding assessing a change in condition and responding appropriately per the resident's code status. Both nurses will be terminated from their positions and referred to the Oklahoma State Board of Nursing . .The facility has assessed each resident under LPN (name deleted) and RN (name deleted) care for changes in condition. The facility has implemented re-education for all nurses regarding CPR, Code Status, and change in condition policies and protocols. Crash carts have been checked for proper supplies and stocked accordingly. All nurses are being evaluated for current CPR certification and certification classes will be conducted as needed to ensure all nurses have current certifications. Mock CPR drills are to be completed per facility policy. The facility has completed an audit of all residents' code status in the EMR. The issues involved in this investigation will be monitored in QAPI monthly and as otherwise needed . On [DATE] at 2:45 p.m. the DON was asked what was done if a staff member noticed a change in a resident's condition. She stated if a CNA noticed a change, she would notify the nurse. She stated the nurse would do a head to toe assessment and notify the resident's physician and family. The DON was asked what would be done if a resident did not respond to stimuli or had no vital signs. She stated they would check the resident's code status. If there were no pulse or respirations and the resident was a full code, they would start CPR,

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) have someone get the crash cart and call 911. The DON was asked how staff would know a resident's code status. She stated the resident's code status was entered into the residents electronic medical record. She stated at the beginning of each shift a print out of all residents code status was provided to the staff members. The DON was asked how staff knew what the facility's emergency protocols were. She stated staff went through orientation on hire and in-service training was provided every two weeks. She stated staff also had online in-service training they had to complete. The DON was asked if there had been recent training regarding emergency protocols and CPR. She stated, yes, a couple of weeks ago on CPR, change of condition and CPR and COVID. She stated CPR training was occurring that day ([DATE]) and the following day ([DATE]). The DON was asked to describe the incident with resident #1 on [DATE]. She stated CNA #1 found the resident unresponsive and reported to LPN #1. She stated LPN #1 came and did an assessment and checked for vital signs. She stated LPN #1 went and got RN#1 to assess the resident. She stated they felt like with their assessment, he had no vital signs and no respirations. The DON was asked what time this occurred. She stated between 5:30 a.m. and 6:00 a.m. The DON was asked what they did next. She stated at 7:00 a.m. LPN #1 gave the day shift nurse, RN #2, a report and stated that resident #1 had passed. The DON stated RN#2 asked what the resident's family had said. LPN #1 stated she had not contacted the family. The DON stated, RN #2 had told LPN #1 that resident #1 had been a full code and she should have begun CPR and notified emergency medical services. The DON stated RN #2 and another night nurse went and began CPR until emergency medical services arrived. She stated emergency medical services had called the code after 20 minutes. The DON was asked if appropriate protocol had been followed with resident #1. She stated, No. The DON was asked if there had been any explanation as to why CPR was not started. She stated she had started an investigation and LPN #1 stated she thought the resident was too far gone and had no pulse or respirations. The DON was asked if LPN #1 knew resident #1 was a full code. She stated LPN #1 said she did. The DON was asked if anything had been documented in the resident's record at the time. She stated, No. She stated LPN #1 had been upset and had been told she could go home and come back later and complete documentation. The DON was asked what had been done after she had completed her investigation. She stated there had been re-education on protocols and procedures and checks of staff CPR status. She stated LPN #1 and RN #1 had been terminated for not following proper protocol. At 3:30 p.m., the DON was asked if LPN #1 and RN #1 were certified in CPR at the time of the incident. She stated they were but the facility did not have copies of their CPR cards. She stated the facility had asked for copies of the cards but they had not been provided. The DON was asked if CPR should have been started when resident #1 had been assessed with [REDACTED].