STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525132	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH CENTRAL HEALTH CARE	1100 LAKE VIEW DR WAUSAU, WI 54403

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 0695 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview the facility did not provide respiratory care for 1 (R1) out of 12 ventilator dependent residents. The systemic failure of all staff to respond to R1's ventilator alarm or call light and to accurately assess the ventilator function placed all 12 ventilator dependent residents at a reasonable expectation for serious harm or death. R1's ventilator alarms were sounding low battery beginning on [DATE] at approximately 6:00 p.m. At 9:30 p.m., R1's ventilator shut off due to power failure. At 9:31 p.m., R1 put his call light on. Staff did not respond to the ventilator alarms or R1's call light once the ventilator turned off. R1 was found unresponsive seated in an electric wheelchair at 9:50 p.m. R1 was pronounced dead at 10:12 p.m. The failure to ensure R1's ventilator was functioning by failing to respond to warning alarms and to R1' call light created a finding of immediate jeopardy, which began [DATE]. The Regional Field Operations Director notified the NHA (Nursing Home Administrator), DON (Director of Nursing), and Regional Administrator of the immediate jeopardy on [DATE] at 11:00 a.m. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan. This is evidenced by: On [DATE], North Winds ventilator unit was staffed with 2 RN (Registered Nurses), 1 RN in training, 2 RTs (Respiratory Therapists), and 3 CNAs (Certified Nursing Assistants) to care for 21 residents. Twelve of the 21 residents were ventilator dependent, including R1. The North Winds call light system and ventilator alarm system were visible and audible out in the hallways on overhead marquees and at the 2 charting stations. The ventilator alarms are gray for low priority, yellow for medium priority, and red for high priority. In addition to the hallway marquees displaying resident needs, the 2 RT staff carried a mobile pager that would signal for any unanswered ventilator alarm. The signal would repeat itself every 2 minutes until the signal was cleared by the RT. According to the facility policy titled Respiratory Procedure-Ventilator Management . RT will carry mobile vent alarm pager which will alert RT if a vent alarm remains on for greater than 2 minutes to provide timely intervention. The pager will not be cleared until after ventilator alarm has been addressed and resolved .Respond to all alarms immediately. R1 was admitted to the facility on [DATE] for long term ventilator dependent care due to DMD (Duchenne [DIAGNOSES REDACTED]). R1 also suffered with [MEDICAL CONDITION] and [DIAGNOSES REDACTED] (heart muscle failure). R1 was dependent on a mechanical ventilator at all times. DMD is a progressive childhood disease ending in death in the 4th decade of life. The cause of death is usually associated with [MEDICAL CONDITION] or a respiratory infection. DMD affects multiple systems as the muscle functions progressively cease. A mechanical ventilator provides life sustaining assistance by breathing in and out for the resident. Upon admission, R1 elected Do Not Resuscitate directives. R1 was capable of making own decisions. R1 was able to make self understood and understand others. R1 was independent in the use of the soft touch call light as well as the sip and blow call light. Review of the care plan initiated in June, 2018 noted R1 required total staff assist for all ADLs (activities of daily living) including eating, toilet use, dressing, hygiene, and bathing. R1 required 2 staff and a mechanical lift for transfers from bed to electric wheelchair. Once in the wheelchair, R1 enjoyed independent mobility throughout the facility. R1 also enjoyed spending time on the computer gaming and on social media sites. The facility submitted a FRI (facility reported incident) to the SA (state agency) on [DATE] which indicated R1 had expired on [DATE] unexpectedly with cause under investigation. The facility conducted a thorough investigation into R1's death and determined R1's death was caused by RT (Respiratory Therapist)-F failure to accurately identify ventilator function and respond to ventilator alarms sounding since approximately 6:00 p.m. on [DATE]. A contributing factor in R1's death was RN-G did not respond to R1's call light. At 9:30 p.m., the ventilator turned off due to power depletion. R1 put on his call light at 9:31 p.m., but no staff responded to the call light until 9:50 p.m. Based on facility interviews, RN-G was at the nurse charting area and aware of R1's call light. At 9:50 p.m., CNA (Certified Nursing Assistant)-H responded to R1's call light and found him unresponsive and without signs of life. CNA-H called for help and a Code Blue was called. RT-F, RN-G, RN-I, and RN-J attempted to resuscitate R1. RT-F stated the ventilator was operating when she removed R1's ventilator connection at the [MEDICAL CONDITION]. RT-F stated she provided rescue breathing via an ambu bag, while RN-G and RN-J assessed for a pulse. RN-I attempted to turn on the ventilator but the screen flashed red as did the battery then turned off again. RN-I noted the power cord was on top of the ventilator. RN-I plugged in the ventilator machine and again turned the machine on. The ventilator machine began to function again and RT-F connected the ventilator machine to R1's [MEDICAL CONDITION]. RN-G telephoned the on call physician who pronounced R1 dead at 10:12 p.m. RT-F disconnected the ventilator machine. The facility interviewed RT-F regarding care provided to R1 on [DATE]. RT-F stated shortly after 6:00 p.m., RT-F entered R1's room and added humidification to his oxygen flow per R1's request. RT-F stated R1 was seated in the electric wheelchair on his computer. At approximately 6:25 p.m., RT-F stated she conducted a respiratory assessment on R1. RT-F stated she noted R1's ventilator was plugged into the wall outlet. This was not accurate as the electrical cord was on top of the ventilator. In addition, the ventilator machine had a green light that turns on when the ventilator was plugged into the electrical outlet and the ventilator screen displayed no battery usage as well. Also, the display window on the ventilator had alarms indicating low detachable battery. RT-F reset these alarms and did not identify the depleting battery situation. RT-F stated she suctioned R1 per his request at 8:30 p.m. and again at 9:30 p.m. According to RTM (Respiratory Therapy Manager)-E, R1's ventilator logs did confirm the 8:30 p.m. suction, but did not confirm the 9:30 p.m. suction. R1's ventilator display window continued to show R1 was using the internal battery, the detachable battery was depleted, and the machine was not plugged into a power source. This information was visible to any RT or RN who interacted with R1 from 6:20 p.m. until when the ventilator turned off at 9:30 p.m. On [DATE] at 10:45 p.m., RTM-E arrived at the facility. RTM-E immediately secured R1's ventilator machine and began reviewing ventilator alarm logs from R1's machine. According to R1's ventilator logs and the facilities investigation, the external or detachable battery was depleted at 6:20 p.m. At that time, R1's ventilator transferred the power source to the internal battery. This battery was the last source of power for the machine. This battery had a life expectancy of approximately 3 hours based on resident usage. R1's ventilator begin to alarm low battery medium priority at 9:08 p.m. when there was 20 minutes of battery life remaining. This alarm rang every 10 seconds for 10 minutes. At 9:18 p.m. the priority of the alarm elevated to high and rang every 5 seconds for 10 minutes. The internal battery was depleted and R1's machine shut off at 9:30 p.m. on [DATE]. Based on the ventilator alarm logs, RTM-E noted R1's ventilator was not plugged into the wall outlet since approximately 7:00 a.m. on [DATE]. RTM-E noted the external detachable battery was depleted at approximately 6:23 p.m. and the internal battery was depleted at approximately 9:30 p.m. and the ventilator turned off. RTM-E confirmed the ventilator was not on and functioning at 9:50 p.m. as RT-F stated. RTM-E noted the ventilator machine sounded low battery alarms for both batteries every 10 seconds for 10 minutes, then every 5 seconds for 10 minutes before turning off, then every 1.5 seconds for 5 minutes after the ventilator turned off due to no battery/power. Review of the call light logs noted R1 activated his call light at 9:31 p.m. The call light remained on and unanswered for greater than 20 minutes before R1 was found unresponsive at 9:50 p.m. R1 expired on [DATE] at 10:12 p.m. due to [MEDICAL CONDITION]. The facility removed the immediate jeopardy on [DATE] when it had completed the

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 0695 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) following: Education on the responsibility and accountability of each persons role in alarm response, battery usage and AC vent plug in. Initiated maintaining visual of the alarms on the marquee and auditory awareness of alarms when not providing cares. Initiated rounding and vent audit for respiratory therapists and nurses to include q2 hour dual signature review of internal and detachable vent battery life and vent AC plugged in. Ensured alarm volumn and vent settings were appropriate on all residents that require ventilation. Policy updated concerning if resident is placed on heated humidity, vent to be placed back on stand and AC power of ventilator should be connected to the wall ensuring that the cord is intact from vent to wall. Updated and included ventilation power status to be recorded on each ventilator check. This check includes AC power connected, detachable battery bar level, internal battery bar level and battery cycle both internal and detachable. Policy updated concerning the need to document suctioning in the EMAR after each suctioning episode. Policy updated concerning RT mobile vent alarm pager. Pager will alert RT if a vent alarm remains on for greater than 2 minutes to provide timely intervention. The pager will not be cleared until after ventilator alarm has been addressed and resolved. Mobile pager will be handed off at report