STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525418	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVANSVILLE MANOR NURSING AND REHAB, LLC	470 GARFIELD AVE EVANSVILLE, WI 53536

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** Based on interview and record review the facility failed to provide basic life support, including CPR (Cardiopulmonary resuscitation), to a resident requiring emergency care and failed to notify emergency medical personnel for 1 of 3 total sampled Residents (R1). R1 was found pulseless and not breathing on [DATE]. R1's Physician order [REDACTED]. Facility failure to begin cardiopulmonary resuscitation and for failing to call 911, created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA A (Nursing Home Administrator), DON B (Director of Nursing) CN F (Corporate Nurse) and CN G of the immediate jeopardy on [DATE] at 4:40 PM. The immediate jeopardy was removed on [DATE]. However the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. This is evidenced by: Per CMS (Centers for Medicare and Medicaid Services) Cardiopulmonary resuscitation (CPR) refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased. Per The American Heart Association, all potential rescuers are to initiate CPR unless a valid Do Not Resuscitate (DNR) order is in place; obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or initiating CPR could cause injury or peril to the rescuer. Per CMS, when addressing full-code residents: If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services. Facility Policy entitled 'Cardio-Pulmonary Resuscitation,' revised on [DATE], states, in part: Purpose: To ensure that all Advanced Directives for each and every resident are individualized by/for that resident, documented and effectively implemented at the facility and that for those residents without an advanced directive or DNR order, full CPR is performed unless clinically contraindicated. Policy: .4. If a resident becomes unresponsive (either witnessed or unwitnessed) the resident's advanced directives/POLST (Physicians Order For Life Sustaining Treatment) will be followed. 5. CPR is to be initiated unless: a. obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or b. initiating CPR could cause injury or peril to the rescuer . Procedure: If a resident is a full code status the following applies: 1. Determine unresponsiveness by shouting are you okay and/or gently shaking or tapping resident. 2. If no response, call for help of other staff members. 3. Instruct other staff responding to scent to obtain emergency supplies and notify [DATE] or emergency personnel. Do not leave Resident. 4. If resident is not face-up, re-position to a face-up position while supporting head, neck and back. To perform CPR ensure resident is placed on a backboard or hard surface. 5. Check resident for breathing or gasping breath while simultaneously checking for a pulse. If either or both are absent initiate CPR. 6. Follow CPR instructions as per American Health Association Healthcare Provider steps . 7. When EMS arrives, they become lead in the resuscitation effort. Follow their directives. 8. Contact resident's physician and family. 9. Document events in medical record . R1 was admitted on [DATE] with [DIAGNOSES REDACTED]. R1's Admission MDS (Minimum Data Set) dated [DATE] indicates that R1 has a BIMS (Brief Interview of Mental Status) of a 4 out of 15 indicating severe cognitive impairment. R1 is dependent on staff for assistance with bed mobility, transfers, toileting and eating. R1's February 2020 MAR (Medication Administration Record) states, in part: Advance Directive Full Code. R1's Care Plan, initiated on [DATE], states, in part: The Resident has advance directives/wishes in place full code . interventions: Code Status: Full Code. R1's Physician Orders, signed on [DATE], state, in part: Full code . order status: active. Order date: [DATE]. R1's [DATE] MAR indicated [REDACTED]. R1 was admitted to Hospice on [DATE]. R1's Hospice Comprehensive Assessment and Plan of Care update report, faxed on [DATE], states, in part: Code Status: Full code. R1's Hospice Visit Note Report, dated [DATE], signed by Hospice RN E (Hospice Registered Nurse), states, in part: In home time began [DATE] at 7:35 AM. .Patient Passed. . Comments related to death: when writer arrived, patient was not breathing and had no pulse. Patient appeared to have passed peacefully. .Narrative: Writer arrived for routine visit, upon assessment patient not breathing and no pulse. Auscultated for 2 minutes, pulse and breath sounds absent. Spoke with daughter (name) and son (name) who said it would be best to not perform chest compressions as it was unknown how long patient had not been breathing. Patient appeared peaceful. Daughter (name) arrived and was tearful but coping appropriately. Low bereavement risk . There is no indication of what time this hospice narrative note was created on [DATE]. On [DATE] at 16:45 (4:45 PM) R1's Nurses Note, states, in part: reported from day shift nurse that resident expired at 0752 this am; body removed from facility at 1645 with all family present and offered no questions at this time; procession provided by staff with funeral director. There is no indication in R1's chart regarding what occurred during R1's passing, whether CPR was initiated or 911 was called. On [DATE] at 12:53 PM, Surveyor interviewed Hospice RN E regarding R1. Hospice RN E indicated she went to the facility to do a routine visit. Hospice RN E indicated when she got to the facility on [DATE], R1 did not appear to be breathing. Hospice RN E indicated she tried to call R1's son and could not get a hold of him, and called R1's daughter. Hospice RN E indicated she told R1's daughter it was unknown how long R1 has not been breathing and that her daughter said no to doing CPR. Hospice RN E indicated she was at the facility around 7:30 AM on [DATE]. Surveyor asked Hospice RN E what she would do if finding a full code hospice patient pulseless and not breathing, Hospice RN E stated, We don't do CPR, yes she was a full code. Hospice RN E indicated that if we find someone, we tell the facility or call 911. Surveyor asked if anyone at the facility was notified, Hospice RN E indicated that an aide walked into R1's room after her and that they (facility staff) were fully aware and the nurse went in. Hospice RN E indicated that the facility did not start compressions and did not call 911. On [DATE] at 1:18 PM, Surveyor interviewed Hospice RN E regarding R1. Hospice RN E indicated from what she remembers, she doesn't recall mottling, and R1's skin wasn't super cool, as if she was laying there for a while. Hospice RN E indicated she just saw that she was not breathing. On [DATE] at 12:39 PM, Surveyor interviewed LPN C (Licensed Practical Nurse) regarding R1 on [DATE]. LPN C indicated she started her medication pass per normal and knew R1 would get a nebulizer treatment and that RN D was training with her. LPN C indicated that RN D went into check on R1 and came out and said I don't think she's breathing. LPN C indicated that the CNA indicated that he/she didn't think she was breathing when he/she did cares. (LPN C is unable to say who the CNA was). LPN C indicated she checked R1's vitals before 7:00 AM, and R1 had no blood pressure, no pulse, and no lung sounds. LPN C indicated she told the Hospice personnel who was there (could not remember if it was a nurse or an aide). LPN C indicated that R1 was cool to the touch and did not have mottling or stiffness. LPN C indicated that she assumed R1 was a DNR due to being Hospice. LPN C indicated she was not aware that R1 was a full code as she never double checked on R1's code status. LPN C indicated that RN D found R1 not Hospice. LPN C indicated she asked hospice about R1 and was not able to verify if R1 was alive and breathing when hospice was doing cares. On [DATE] at 1:03 PM, Surveyor interviewed RN D regarding R1 on [DATE]. RN D indicated she went into R1's room and Hospice was in there with R1. RN D indicated she looked at R1 and that

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) R1 looked like she passed away. RN D indicated that Hospice personnel said to her that R1 was a full code, she wasn't breathing and had no heart rate. RN D indicated R1 did not seem to have mottling and that she felt like she hadn't been dead long. Surveyor asked RN D to walk her through what to do if finding a full code resident pulseless and not breathing, RN D indicated, Well the hospice lady was running the show. RN D indicated that she does not know whether CPR should have been initiated on R1 or not. RN D indicated they were unaware of how long she'd been gone. On [DATE] at 12:20 PM, Surveyor interviewed CN G (Corporate Nurse) and CN F regarding R1. CN F indicated the Hospice nurse entered the room and declared her deceased . CN G indicated per Hospice, the nurse talked to our CNA who was in R1's room prior and said she was okay and then when Hospice RN E found obvious signs of death, she determined she was deceased , as Hospice is able to declare death. On [DATE] at 9:54 AM, Surveyor interviewed POA H (Power of Attorney) regarding R1. POA H indicated that the facility would not give her information, and that she is unaware of what went on. POA H indicated that no one from the facility talked to her brother, who is R1's other POA. POA H indicated that R1 was a full code and that she received a call around 7:52 AM on [DATE], telling her they were not sure how long R1 has been without a pulse. POA H indicated the person on the phone asked her if I wanted her revived. POA H indicated she questioned why they would call me and say she doesn't have vitals and then ask if I wanted her revived when she's a full code. On [DATE] at 12:51 PM, Surveyor interviewed POA H a second time related to R1. POA H indicated she told them (staff) not to touch her and asked why they didn't initiate CPR. POA H indicated that staff did not answer that question. R1's Cause of Death form, dated [DATE], indicates Diastolic heart failure, stage 4 [MEDICAL CONDITION] and NSTEMI with years in between onset and death. On [DATE] at 3:49 PM, Surveyor interviewed MD J (Medical Director) regarding R1. Surveyor asked if CPR should be initiated on a Resident who is a full code, MD J stated, Yes, along with dialing 911 for help. MD J indicated that if someone knew she (R1) was a full code, with good communication and knowledge of being a full code, yes they're to initiate CPR and dial 911. The failure to begin cardiopulmonary resuscitation and for failing to call 911, created a finding of Immediate Jeopardy. The facility removed the jeopardy on [DATE], when it had completed the following: The facility will immediately complete a root cause analysis regarding incident with (R1) and implement immediate interventions as detailed below to prevent future incidents. Root cause determined to be communication issue between Hospice nurse and facility staff. The facility will immediately conduct an in-house chart audit of all patients signed code status to include advance directive forms, physician order [REDACTED]. Completed [DATE]. The facility will audit all RN and LPN CPR certifications to ensure up to date. Completed [DATE]. All Hospice providers contacted and provided education regarding process expectations upon finding a Full Code Resident pulseless or breathless. Hospice provider must immediately alert Facility staff of code and stay with the Resident. Facility staff will initiate CPR. Education started on [DATE] and will continue until all hospice staff educated. All staff, including agency and contracted staff, will be educated prior to their next working shift on the following: 1. Identification of code status: Full code vs. DNR and need to immediately initiate CPR for all residents deemed Full code to include all residents even those on Hospice Services. 2. All Hospice personnel will immediately be educated on the need to follow Residents wishes including providing CPR to those residents requesting CPR and to immediately initiate emergency procedures when a resident is deemed full code. CPR code drill conducted [DATE]. Like Residents: House Audit conducted of all Residents' code status on [DATE]. There are currently no Residents in house on Hospice Services that is also a full code. Validation of CPR certification to be completed upon employment and annually upon license verification on [DATE]; to be completed by HR (Human Resources) or designee. Verified all Residents' current code status accurately reflected in PCC on banner in both POC (Point of Care) and PCC (Point Click Care) on [DATE]. All staff including agency and contracted staff, will be educated prior to their next working shift on the following: 1. Identification of code status: Full code Vs. DNR and need to immediately initiate CPR for all residents deemed full code to include all residents even those on Hospice Services. 2. All Hospice personnel will immediately be educated on the need to follow residents wishes including providing CPR to those residents requesting CPR and to immediately initiate emergency procedures when a resident is deemed full code. All Hospice providers contacted and provided education regarding process expectations upon finding a full code resident pulseless or breathless. Hospice provider must immediately alert facility staff of code and stay with the Resident. Facility staff will initiate CPR. System Correction: Facility will immediately review, update and educate all staff on CPR Policy and Procedure related to current American Heart Association (AHA) recommendations for providing CPR. System correction is focused on education related to following code status. Education will include all nursing staff and will be ongoing until all staff are educated. Staff will receive education prior to their next shift. Hospice Residents that also have a full code status will have this status clearly outlined on their PCC (point click care) and POC (Point of Care) banner. All hospice providers contacted and provided education regarding process expectations upon finding a full code resident pulseless or breathless. Hospice provider must immediately alert facility staff of code and stay with the Resident. Facility staff will initiate CPR. Changes in code status will be discussed in the morning meeting. Unit managers will update licensed status in the event of change of code status after the morning meeting. Care plans and code status demonstration will be updated on resident's records. Mock code blue drills will be immediately conducted on every shift starting [DATE] for 1 week, then weekly x 4 (times four), and monthly thereafter. Results will be reviewed at QAPI. Education - was initiated immediately: Education regarding emergency response and CPR initiation initiated immediately. Education will include all nursing staff and will be on going until all staff are educated. Staff will receive education prior to their next shift. Education is being issued via in-person in-servicing. Phone education is being implemented to target staff members who are not in the facility with validation by signature prior to the start of their next shift. A facility master staff roster is presently utilized to ensure staff members receive education. All Hospice providers contacted and provided education regarding process expectations upon finding a full code resident pulseless or breathless. Hospice provider must immediately alert facility staff of code and stay with the Resident. Facility will initiate CPR. Monitoring: DON or Designee is responsible to complete QA (Quality Assurance) tool on: Code status audits of new admits daily x 1 week, 3 x/week x 3 weeks, and weekly x 1 month. Code status then reviewed with quarterly care plan review and at the time of Hospice Service Admission. Mock code blue drills will be immediately conducted on every shift starting [DATE] for 1 week, then weekly x 4, and monthly thereafter. Results will be reviewed at QAPI. Summation of audit tool presented quarterly to QAPI (Quality Assurance and Performance Improvement) Committee. The Medical Director was updated on this correction and removal-abatement plan as well as occurrences of which this plan pertains. Monitoring will be initiated and completed by the Administrator and/or designee as indicated above. Any discrepancies identified during completion of these audits will be immediately addressed. All audits, reviews and interviews will be forwarded to the Center's QAPI (Quality Assurance Performance Improvement) committee to identify patterns and trends of noncompliance and to determine if further action is necessary. Frequency of continued audits will be determined at that time. If issues are identified, re-education will be completed. If any trends are identified, systems will be assessed to determine effectiveness. A plan will be developed and revisions will be made as deemed necessary.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Observe each nurse aide's job performance and give regular training.** Based on interview and record review, the facility did not ensure Certified Nursing Assistants (CNAs) receive a performance review at least every 12 months for 2 of 5 staff members selected for review. CNA N was hired on 5/17/19, did not have an evaluation in the past 12 months. CNA M was hired on 4/30/19, did not have an evaluation in the past 12 months. This is evidenced by: Facility Policy entitled 'Performance Evaluation,' (no date), states, in part: .All full-and-part- time employees are eligible for an annual performance review . Performances appraisals, are conducted on an annual cycle. Employees will receive performance review on the established date each year. .Responsibility: HR (Human Resources) Director is responsible for distributing performance evaluations forms as well as monitoring the completion and implementation of the process. The completed performance evaluation will be retained in the employee's personnel file. The performance evaluation will be discussed and signed by both the employee and the manager to ensure that all strengths, areas for improvement and job goals for the next review period are clearly communicated. Example 1: CNA N (Certified Nursing Assistant) was hired on 5/17/19, did not have an evaluation in the past 12 months. CNA N was due for an evaluation on or around 5/17/20. CNA N's Employee Evaluation, Form does not have a date to indicate when it was filled out. The form does not have a signature from the Reviewer, or CNA N indicating CNA N received her annual review. On 6/29/20 at 12:05 PM, Surveyor interviewed HR O (Human Resources) regarding CNA N. HR O indicated annual reviews are given out at the end of the month, before they are due. HR O indicated she is responsible for tracking attendance and training hours for staff. HR O indicated she tries to track performance reviews timely and the DON (Director of Nursing) and ADON (Assistant Director of Nursing) are responsible for CNA reviews. HR O indicated CNA N's review was not completed as of 6/29/20 due to CNA N only

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F 0730 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) works the weekends. HR O indicated that CNA N did not receive her review timely. HR O indicated CNA N has not had any previous reviews as she's only been here a year. Example 2: CNA M (Certified Nursing Assistant) was hired on 4/30/19, did not have an evaluation in the past 12 months. CNA M was due for an evaluation on or around 4/30/20. CNA M's Employee Evaluation, Form is incomplete as it is not completely filled out. There is no signature from CNA M or a Reviewer. There is no date indicating when the review was initiated, and there are multiple blank boxes. On 6/29/20 at 12:05 PM, Surveyor interviewed HR O (Human Resources) regarding CNA M. HR O indicated CNA M did not receive her review timely. HR O indicated CNA M has not had any previous reviews as she's only been here a year.
F 0849 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 1 or 2 Hospice residents out of a total sample of 3 Residents (R1). R1's plan of care was not coordinated and communicated adequately between the facility and Hospice. The hospice service agreement did not specify if hospice staff would or would not provide cardiopulmonary resuscitation (CPR). R1 desired to be a full code and CPR was not initiated when the hospice nurse found R1 pulseless and nonbreathing. Facility failure to coordinate care with hospice, for failing to know, and for failing to spell out in the hospice service agreement, what care hospice would and would not provide, created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA A (Nursing Home Administrator), DON B (Director of Nursing), CN F (Corporate Nurse) and CN G of the immediate jeopardy on [DATE] at 4:40 PM. The immediate jeopardy was removed on [DATE]. However the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. This is evidenced by: Facility Policy entitled 'Hospice,' dated [DATE], states, in part: It is the policy of (Name of company) to follow a written procedure for admitting and caring for a resident choosing to be on Hospice and to ensure the facility communicates, establishes, and agrees upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on an individualized assessment of the resident's needs. New referral process: . The resident must meet Hospice criteria: life expectancy of 6 months or less, opt for palliative care, and preferably be a DNR (Do not Resuscitate) status . Skilled Nursing: . A completed hospice care plan must be made available for the resident's chart from hospice. .Care Plans: The hospice nurse and IDT will develop the hospice portion of the care plan. .The skilled nursing facility care plan will be merged with the hospice plan of care so the resident will have an integrated plan of care. The joint care plan will be kept in the care plan section of the resident's chart. Facility Contract/Agreement, for Hospice states, in part: 4. Duties and obligations of facility. .4.1 Services. Facility will furnish to Hospice Patients all services needed to meet the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected . 4.11 Staff Qualifications. All Facility staff who render services of any kind to Hospice Patients under this Agreement must be fully qualified, licensed, certified and registered, as applicable in accordance with applicable federal, state and local laws and must act only within the scope of their state license, certification, or registration in their respective disciplines and in compliance with professional standards . 7. Advance Directives. Hospice and Facility will comply with federal Patient Self-Determination Act. Hospice and Facility will inform each Hospice patient about advance directives under applicable state law . The facility's service agreement with hospice does not outline the responsibilities of either the hospice staff or the facility staff when a full-code resident is found pulseless and non-breathing. Hospice Agency's Policy, entitled 'Resuscitative Guidelines,' dated ,[DATE], states in part: 1. (Agency Name) employees are not required to be certified in CPR in order to perform basic life support in an emergency. 2. Hospice patients and families are informed regarding resuscitative guidelines verbally and in writing included in the Admission Supplement. 3. Each agency is responsible to know and adhere to any state specific regulations related to CPR. 4. In the event an employee encounters a patient who is a full code: a. If comfortable performing and or has training in basic life support, call 911 and initiate CPR. b. If no training or uncomfortable with initiating basic life support, call 911. 5. If states require staff to provide resuscitative measures, the agency will be responsible for ensuring staff complete necessary CPR certification courses (online CPR certification is not acceptable). R1 was admitted on [DATE] with [DIAGNOSES REDACTED]. R1 was admitted to Hospice on [DATE]. R1's Hospice Comprehensive Assessment and Plan of Care update report, faxed on [DATE], states, in part: Code Status: Full code. R1's Hospice Visit Note Report, dated [DATE], signed by Hospice RN E (Hospice Registered Nurse), states, in part: In home time began [DATE] at 7:35 AM. .Patient Passed. . Comments related to death: when writer arrived, patient was not breathing and had no pulse. Patient appeared to have passed peacefully. .Narrative: Writer arrived for routine visit, upon assessment patient not breathing and no pulse. Auscultated for 2 minutes, pulse and breath sounds absent. Spoke with daughter (name) and son (name) who said it would be best to not perform chest compressions as it was unknown how long patient had not been breathing. Patient appeared peaceful. Daughter (name) arrived and was tearful but coping appropriately. Low bereavement risk . There is no indication of what time this hospice narrative note was created on [DATE]. On [DATE] at 16:45 (4:45 PM) R1's Nurses Note, states, in part: reported from day shift nurse that resident expired at 0752 this am; body removed from facility at 1645 with all family present and offered no questions at this time; procession provided by staff with funeral director. There is no indication in R1's chart regarding what occurred during R1's passing, whether CPR was initiated or 911 was called. On [DATE] at 12:53 PM, Surveyor interviewed Hospice RN E regarding R1. Hospice RN E indicated she went to the facility to do a routine visit. Hospice RN E indicated when she got to the facility on [DATE], R1 did not appear to be breathing. Hospice RN E indicated she tried to call R1's son and could not get a hold of him, and called R1's daughter. Hospice RN E indicated she told R1's daughter it was unknown how long R1 has not been breathing and that her daughter said no to doing CPR. Hospice RN E indicated she was at the facility around 7:30 AM on [DATE]. Surveyor asked Hospice RN E what she would do if finding a full code hospice patient pulseless and not breathing, Hospice RN E stated, We don't do CPR, yes she was a full code. Hospice RN E indicated that if we find someone, we tell the facility or call 911. Surveyor asked if anyone at the facility was notified, Hospice RN E indicated that an aide walked into R1's room after her and that they (facility staff) were fully aware and the nurse went in. Hospice RN E indicated that the facility did not start compressions and did not call 911. On [DATE] at 1:18 PM, Surveyor interviewed Hospice RN E regarding R1. Hospice RN E indicated from what she remembers, she doesn't recall mottling, and R1's skin wasn't super cool, as if she was laying there for a while. Hospice RN E indicated she just saw that she was not breathing. There is no indication that Hospice RN E told facility staff that R1 was full code, if the facility staff were told to initiate CPR or call 911. There is no indication documented as to why Hospice RN E did not initiate CPR on R1 or call 911 herself. On [DATE] at 11:49 AM, NHA A came to Surveyor and indicated that a CNA had been in there 10 minutes prior. On [DATE] at 12:39 PM, Surveyor interviewed LPN C (Licensed Practical Nurse) regarding R1 on [DATE]. LPN C indicated she started her medication pass per normal and knew R1 would get a nebulizer treatment and that RN D was training with her. LPN C indicated that RN D went into check on R1 and came out and said I don't think she's breathing. LPN C indicated that the CNA indicated that he/she didn't think she was breathing when he/she did cares. (LPN C is unable to say who the CNA was). LPN C indicated she checked R1's vitals before 7:00 AM, and R1 had no blood pressure, no pulse, and no lung sounds. LPN C indicated she told the Hospice personnel who was there (could not remember if it was a nurse or an aide). LPN C indicated that R1 was cool to the touch and did not have mottling or stiffness. LPN C indicated that she assumed R1 was a DNR due to being Hospice. LPN C indicated she was not aware that R1 was a full code as she never double checked on R1's code status. LPN C indicated that RN D found R1 not Hospice. LPN C indicated she asked hospice about R1 and was not able to verify if R1 was alive and breathing when hospice was doing cares. There is no indication that Hospice RN E informed LPN C that R1 was a full code, or instructed LPN C to start CPR or to call 911. On [DATE] at 1:03 PM, Surveyor interviewed RN D regarding R1 on [DATE]. RN D indicated she went into R1's room and Hospice was in there with R1. RN D indicated she looked at R1 and that R1 looked like she passed away. RN D indicated that Hospice personnel said to her that R1 was a full code, she wasn't breathing and had no heart rate. RN D indicated R1 did not seem to have mottling and that she felt like she hadn't been dead long. Surveyor asked RN D to walk her through what to do if finding a full code resident pulseless and not breathing, RN D indicated, Well the hospice lady was running the show. RN D indicated that she does not know whether CPR should have been initiated on R1 or not. RN D indicated they were unaware of how long she'd been gone. On [DATE] at 12:20 PM, Surveyor interviewed CN G (Corporate Nurse) and CN F regarding R1. CN F indicated the Hospice nurse entered the room and declared

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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 0849 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) her deceased . CN G indicated per Hospice, the nurse talked to our CNA who was in R1's room prior and said she was okay and then when Hospice RN E found obvious signs of death, she determined she was deceased , as Hospice is able to declare death. On [DATE] at 9:54 AM, Surveyor interviewed POA H (Power of Attorney) regarding R1. POA H indicated that the facility would not give her information, and that she is unaware of what went on. POA H indicated that no one from the facility talked to her brother, who is R1's other POA. POA H indicated that R1 was a full code and that she received a call around 7:52 AM on [DATE], telling her they were not sure how long R1 has been without a pulse. POA H indicated the person on the phone asked her if I wanted her revived. POA H indicated she questioned why they would call me and say she doesn't have vitals and then ask if I wanted her revived when she's a full code. On [DATE] at 12:51 PM, Surveyor interviewed POA H a second time related to R1. POA H indicated she told them (staff) not to touch her and asked why they didn't initiate CPR. POA H indicated that staff did not answer that question. On [DATE] at 1:52 PM, Surveyor interviewed CN F and CN G regarding R1. CN G indicated for R1 signs of death is absence of breath and no pulse. CN F and CN G both indicated they were unaware that hospice does not do CPR per Hospice RN E. On [DATE] at 2:15 PM, Surveyor interviewed NHA A regarding Hospice initiating CPR. NHA A indicated that she was unaware that Hospice does not initiate CPR. On [DATE] at 4:19 PM, Surveyor interviewed Hospice DPS I (Director of Professional Services) regarding CPR. Hospice DPS I indicated the facility receives a copy of admission paper work, and would have code status on hand. Hospice DPS I indicated if deceased for a while, CPR would not be initiated, would call 911 as it depends on the clinician's comfortability with initiating CPR. Hospice DPS I indicated if the clinician is not comfortable they're to call 911 for a full code. Surveyor asked Hospice DPS I about R1 being a full code, Hospice DPS I indicated, it depends, if they're dead and have been dead whether or not CPR should be started, but our policy states to call 911. Hospice DPS I indicated Hospice policies and procedures are sent over if requested. Hospice DPS I indicated she faxed the policy to the facility. There is no evidence that the facility requested policies and procedures from Hospice for advance directives prior to [DATE]. On [DATE] at 3:49 PM, Surveyor interviewed MD J (Medical Director) regarding R1. MD J indicated that if someone knew she (R1) was a full code, with good communication and knowledge of being a full code, yes they're to initiate CPR and dial 911. The failure to coordinate care with hospice, for failing to know, and for failing to spell out in the hospice service agreement, what care hospice would and would not provide, created a finding of Immediate Jeopardy. The facility removed the jeopardy on [DATE], when it had completed the following: The facility will immediately completed a root cause analysis regarding incident with (R1) and implement immediate interventions as detailed below to prevent future residents. Root cause determined to be communication issue between Hospice nurse and facility staff. The facility will immediately conduct an in-house chart audit of all patients signed code status to include advance directive forms, physician order [REDACTED]. Completed [DATE]. The facility will audit all RN and LPN CPR certifications to ensure up to date. Completed [DATE]. All Hospice providers contacted and provided education regarding process expectations upon finding a Full Code Resident pulseless or breathless. Hospice provider must immediately alert Facility staff of code and stay with the Resident. Facility staff will initiate CPR. Education started on [DATE] and will continue until all hospice staff educated. All staff, including agency and contracted staff, will be educated prior to their next working shift on the following: 1. Identification of code status: Full code vs. DNR and need to immediately initiate CPR for all residents deemed Full code to include all residents even those on Hospice Services. 2. All Hospice personnel will immediately be educated on the need to follow Residents wishes including providing CPR to those residents requesting CPR and to immediately initiate emergency procedures when a resident is deemed full code. CPR code drill conducted [DATE]. Like Residents: House Audit conducted of all Residents' code status on [DATE]. There are currently no Residents in house on Hospice Services that is also a full code. Validation of CPR certification to be completed upon employment and annually upon license verification on [DATE]; to be completed by HR (Human Resources) or designee. Verified all Residents' current code status accurately reflected in PCC on banner in both POC (Point of Care) and PCC (Point Click Care) on [DATE]. All staff including agency and contracted staff, will be educated prior to their next working shift on the following: 1. Identification of code status: Full code Vs. DNR and need to immediately initiate CPR for all residents deemed full code to include all residents even those on Hospice Services. 2. All Hospice personnel will immediately be educated on the need to follow residents wishes including providing CPR to those residents requesting CPR and to immediately initiate emergency procedures when a resident is deemed full code. All Hospice providers contacted and provided education regarding process expectations upon finding a full code resident pulseless or breathless. Hospice provider must immediately alert facility staff of code and stay with the Resident. Facility staff will initiate CPR. System Correction: Facility will immediately review, update and educate all staff on CPR Policy and Procedure related to current American Heart Association (AHA) recommendations for providing CPR. System correction is focused on education related to following code status. Education will include all nursing staff and will be ongoing until all staff are educated. Staff will receive education prior to their next shift. Hospice Residents that also have a full code status will have this status clearly outlined on their PCC (point click care) and POC (Point of Care) banner. All hospice providers contacted and provided education regarding process expectations upon finding a full code resident pulseless or breathless. Hospice provider must immediately alert facility staff of code and stay with the Resident. Facility staff will initiate CPR. Changes in code status will be discussed in the morning meeting. Unit managers will update licensed status in the event of change of code status after the morning meeting. Care plans and code status demonstration will be updated on resident's records. Mock code blue drills will be immediately conducted on every shift starting [DATE] for 1 week, then weekly x 4 (times four), and monthly thereafter. Results will be reviewed at QAPI. Education - was initiated immediately: Education regarding emergency response and CPR initiation initiated immediately. Education will include all nursing staff and will be on going until all staff are educated. Staff will receive education prior to their next shift. Education is being issued via in-person in-servicing. Phone education is being implemented to target staff members who are not in the facility with validation by signature prior to the start of their next shift. A facility master staff roster is presently utilized to ensure staff members receive education. All Hospice providers contacted and provided education regarding process expectations upon finding a full code resident pulseless or breathless. Hospice provider must immediately alert facility staff of code and stay with the Resident. Facility will initiate CPR. Monitoring: DON or Designee is responsible to complete QA (Quality Assurance) tool on: Code status audits of new admits daily x 1 week, 3 x/week x 3 weeks, and weekly x 1 month. Code status then reviewed with quarterly care plan review and at the time of Hospice Service Admission. Mock code blue drills will be immediately conducted on every shift starting [DATE] for 1 week, then weekly x 4, and monthly thereafter. Results will be reviewed at QAPI. Summation of audit tool presented quarterly to QAPI (Quality Assurance and Performance Improvement) Committee. The Medical Director was updated on this correction and removal-abatement plan as well as occurrences of which this plan pertains. Monitoring will be initiated and completed by the Administrator and/or designee as indicated above. Any discrepancies identified during completion of these audits will be immediately addressed. All audits, reviews and interviews will be forwarded to the Center's QAPI (Quality Assurance Performance Improvement) committee to identify patterns and trends of noncompliance and to determine if further action is necessary. Frequency of continued audits will be determined at that time. If issues are identified, re-education will be completed. If any trends are identified, systems will be assessed to determine effectiveness. A plan will be developed and revisions will be made as deemed necessary.