STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225239	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATTLEBORO HEALTHCARE	**27 GEORGE STREET ATTLEBORO, MA 02703**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of eight sampled residents (Resident #1), whose advanced directives included he/she was an Attempt Resuscitation (in the event of cardiac or respiratory arrest, all attempts at resuscitation will be initiated), and to Transfer to the Hospital, the Facility failed to ensure nursing staff provided pertinent and accurate information to the Physician, when on [DATE], Resident #1 was found unresponsive and experiencing a sudden and life threatening change in condition. Finding includes: Review of the Facility's Change in a Resident's Condition or Status Policy, dated ,[DATE], indicated that, the Facility professional staff will communicate with physician, participant, and family regarding changes in condition. The Policy indicated that, prior to notifying the physician or healthcare provider, the nurse will make detailed observation and gather relevant information for the provider. Resident #1's Advance Directives, documented on a Massachusetts Medical Order of Life Sustaining Treatment (MOLST) Record, dated [DATE], indicated Resident #1's code status included to Attempt Resuscitation (CPR), Use Non-Invasive Ventilation and Transfer to Hospital. Resident #1's [DIAGNOSES REDACTED]. The Facility's Investigation Report, dated [DATE], indicated that Nurse #2 , who is a Licensed Practical Nurse (LPN), did not review Resident #1's Medical Orders for Life Sustaining Treatment (MOLST) information at the time of the incident, and that Nurse #2 did not accurately report the correct MOLST information to the Physician. During an interview on [DATE] at 9:45 A.M., the Physician said he received a call from Nurse #2 on [DATE], (exact time unknown), that Nurse #2 said Resident #1 was found with no vital signs and that he/she was dead. The Physician said Nurse #2 told him that Resident #1 was a Do Not Resuscitate (DNR). The Physician said he told Nurse #2 to follow the Facility protocol and gave an order for [REDACTED]. and on [DATE] at 12:00 P.M., Nurse #2 said that during her routine rounds on [DATE] at 11:40 P.M., she found Resident #1 in bed, unresponsive with no pulse and no respirations. Nurse #2 said she called the Physician and said she reported that Resident #1 was unresponsive and without a pulse. Nurse #2 said the Physician told her to follow the Facility's protocol and gave an order for [REDACTED]. The Physician said by this time, Resident #1 had already been pronounced dead.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on records reviewed and interviews, for five of eight sampled personnel files (Director of Nurses (DON) #1, DON #2, Administrator #1, Administrator #2, and the Medical Director), the Facility failed to ensure that pre-employment screening was conducted in accordance with facility policy. Findings include: The Facility's Abuse Screening Policy, dated as last revised 12/2017, indicated that it included: - Prospective employees will complete an employee application form; - The person responsible for hiring the prospective employee will ensure that a good faith attempt has been made to obtain a minimum of two previous employment references unless the prospective employee has not been previously employed; - The Nurse Aide Registry is checked prior to employment for all facility employees; - The person responsible for hiring will ensure that the request for the required criminal background check (CORI (Criminal Offender Record Information)) has been submitted no later than the date of initial orientation; and, - Documentation on all of the above information will be maintained as part of the employment record. During interview at 10:29 A.M. on 09/16/20, the Business Office Manager said she was also responsible for Human Resources, which included the Facility's personnel files. The Business Office Manager said an employee's personnel file contents should include, but were not limited to, a completed application, a minimum of two reference checks, evidence of a licensure or certification verification, and a nurse aide registry check. 1. Director of Nurses (DON) #1 was hired by the Facility in June 2020. Review of DON #1's personnel file indicated that it did not include any reference checks. Review of DON #1's New Hire Checklist, undated, indicated that at least two references had been checked and documented by the hiring manager. The Business Office Manager said that DON #1's reference checks should have been included in her personnel file. 2. Administrator #1 was hired by the Facility in June 2020. Review of Administrator #1's personnel file indicated that it did not include any reference checks. Review of Administrator #1's New Hire Checklist, undated, indicated that it did not include the completion of at least two reference checks. The Business Office Manager said she was not responsible for completing Administrator #1's reference checks as she was not his hiring manager. The Business Office Manager said reference checks for the Facility's Administrator, including Administrator #1 and Administrator #2, were not be included in their personnel files because they were in a supervisory position and she should not have access to them. 3. Administrator #2 was hired by the Facility in February 2020. Review of Administrator #2's personnel file indicated that it did not include: a completed application, Nurse Aide Registry check, or documentation of a submitted request for a CORI check. During interview at 7:18 A.M. and throughout the day on 09/16/20, Administrator #1 said he provided the Surveyor with Administrator #2's personnel file as it was provided to him. Administrator #1 confirmed that Administrator #2's personnel file did not include a completed application, Nurse Aide Registry check, or documentation of a submitted request for a CORI check. 4. DON #2 was hired by the Facility in March 2019. Review of DON #2's personnel file indicated that it did not include an application for employment. Review of DON #2's New Hire Checklist, undated, indicated that an application was completed and signed by the candidate. The Business Office Manager said DON #2's application was not included in his personnel file. 5. Review of the Medical Director's personnel file indicated that it included a revised contract for employment dated in December 2008. The File did not include documentation of a Nurse Aide Registry check, submitted request for a CORI check, or reference checks. Administrator #1 said the Medical Director had been employed by the Facility for many years, and it was possible that the Facility's prior ownership company retained her personnel file. Administrator #1 said the Facility did not have documentation to support that a Nurse Aide Registry check, submitted request for a CORI check, or reference checks were completed for the Medical Director. There was no documentation to support that personnel files for DON #1, DON #2, Administrator #1, Administrator #2, and the Medical Director included a completed application for employment, reference checks, Nurse Aide Registry check, and/or documentation of a submitted request for a CORI check, in accordance with Facility policy.
F 0658 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of eight sampled residents (Resident #1), whose advanced directives indicated he/she was an Attempt Resuscitation (in the event of cardiac or respiratory arrest, attempts at resuscitation will be initiated) and Transfer to Hospital, the Facility failed to ensure that staff followed acceptable standards of practice to respond to an emergency situation. When on [DATE], after Nurse #2, who was an Licensed Practical Nurse (LPN) and was CPR certified, found Resident #1 unresponsive, without a pulse or respirations, Nurse #2 did not call a Code Blue, Nurse #2 did not perform cardiopulmonary resuscitation (CPR) correctly, Nurse #2 did not activate 911, and provided

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225239	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATTLEBORO HEALTHCARE	27 GEORGE STREET ATTLEBORO, MA 02703

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 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) inaccurate information regarding Resident #1's Code Status to the Physician, when she reported Resident #1 was a DNR (Do Not Resuscitate). - At 11:40 P.M., Nurse #2 found Resident #1 unresponsive, with no pulse, no respirations and his/her lower extremities were cold with the presence of mottling (mottled skin, before death, presents as a red or marbled appearance) to his/her skin. Nurse #2, in an attempt to perform CPR only gave Resident #1 three chest compressions, stopped and then left Resident #1 alone to go get help. - At 11:50 P.M., Nurse #2 called the Physician and reported that Resident #1 was unresponsive, was absent of vital signs and reported incorrectly that Resident #1 was a Do Not Resuscitate (DNR) code status. The Physician based on this information, instructed Nurse #2 to follow Facility protocol and then gave an order for [REDACTED].M, despite getting a physician's orders [REDACTED].#2 returned to Resident #1's room with the code cart accompanied by Certified Nurse Aide (CNA) #1 and CNA #2 and attempted to perform CPR on him/her. Nurse #2 gave two sets of chest compressions while CNA #1 gave two rescue breaths with an Ambu bag (an artificial manual breathing unit). Nurse #2 then administered [MEDICATION NAME] (can treat narcotic overdose in an emergency situation) spray in both nostrils. Although Nurse #2 brought the automated external defibrillation (AED, an electronic device that automatically [DIAGNOSES REDACTED].#1. There was no page for Code Blue with the intercom system and 911 was not called. - At 12:00 A.M., Nurse #2 again stopped CPR on Resident #1, left her unit and went downstairs to another nursing unit to request help with Resident #1 from Nurse #3. Nurse #2 told Nurse #3 (also an LPN) she had a physician's orders [REDACTED]. Nurse #3 went to Resident #1's room, assessed him/her and told Nurse #2 that Resident #1 was dead. - [DATE] at 9:10 A.M., when an RN reported for work on the day shift, the RN assessed Resident #1 and completed the RN pronouncement Form. Findings include: Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Review of The American Heart Association Guidelines, dated 2015, indicated that the sequence of intervention with discovery of an individual in cardiac or respiratory arrest includes: - Verify scene safety, if victim is unresponsive, shout for nearby help. - Activate emergency response system via mobile device (if appropriate). - Get AED and emergency equipment (or send someone to do so). - Look for no breathing or only gasping and check pulse (simultaneously), is pulse felt within 10 seconds? - If No breathing or only gasping, no pulse; begin CPR with cycles of 30 compressions and 2 breaths. - Use AED as soon as it is available. - AED arrives, check rhythm. Is rhythm shockable? - If Yes, Give 1 shock. Resume CPR immediately for about 2 minutes (until prompted by AED to allow rhythm check). Continue until ALS (Advanced Life Support) providers take over or victim starts to move. - If non-shockable rhythm, to resume CPR immediately for about 2 minutes (until prompted by AED to allow rhythm check). Continue until ALS providers take over or victim starts to move. The Guidelines indicated that the rescuer should perform chest compressions at a rate of ,[DATE]/min, Compress to a depth of less than 2 inches (5 centimeters, cm) or greater than 2.4 inches (6 cm), to minimize pauses in chest compressions and to ventilate adequately (2 breaths after 30 compressions, each breath delivered over 1 second, each causing chest rise). The Guidelines also indicated that the rescuer should not Compress at a rate slower than 100/min or faster than 120/min Compress to a depth of at least 2 inches (5 cm), should allow full recoil after each compression, should not lean on the chest between compressions and should not interrupt compressions for greater than 10 seconds. Review of the Facility's Emergency Procedure-Cardiopulmonary Resuscitation Policy, dated ,[DATE], indicated that, if an individual (resident, visitor, or staff) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR shall initiate CPR unless it is known that a Do Not Resuscitation (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual. Review of the Facility's Code Blue Policy, dated ,[DATE], indicated that, the nurse is the first responder to the situation will determine (or delegate to another nurse) the code status, lead the code, and remain with the patient throughout the code. For Full code victim, the nurse as first responder will give direction to other staff who respond to the code and determine which staff will perform CPR, call 911, retrieve emergency cart, retrieve medical record and record the code. The Policy also indicated that CPR will not be initiated if (a) the resident has a current, valid Do Not Resuscitate (DNR) or MOLST form indicating DNR and or (b) attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril. Resident #1's [DIAGNOSES REDACTED]. Resident #1's Advance Directives, documented on a Massachusetts Medical Order of Life Sustaining Treatment (MOLST) Record, dated [DATE], indicated Resident #1's code status included to Attempt Resuscitation (CPR), Use Non-Invasive Ventilation and Transfer to Hospital. Review of Nurse #2's written Witness Statement, dated [DATE], indicated that she (Nurse #2) found Resident #1 unresponsive to touch and voice, had no respirations, no blood pressure and that his/her extremities were cold, pale and mottled. The Statement indicated that she (Nurse #2) performed a sternal rub, administered [MEDICATION NAME] (per facility policy for residents found unresponsive) and contacted the Physician who ordered an RN Pronouncement and for the body to be released to the funeral home. During interviews on [DATE] at 9:10 A.M. and on [DATE] at 12:00 P.M., Nurse #2 said she found Resident #1 unresponsive with no pulse and no respirations in bed during her routine rounds on [DATE] at 11:40 P.M. Nurse #2 said she did three chest compressions, stopped and went to get help. Nurse #2 said she yelled out for Certified Nurse Aide (CNA) #1 and CNA #2 that Resident #1 was unresponsive and said that she went to the nurse's station and made calls to Nurse #3, the Physician, the Administrator and the Director of Nurses (DON) before taking the code cart to Resident #1's room. However, according to the American Heart Association Guidelines, dated 2015, indicated that once CPR is initiated, the rescuer should not interrupt chest compressions for greater than 10 seconds. Nurse #2 said it took five to ten minutes before she could return to Resident #1's room to resume CPR on him/her. Nurse #2 said that although she brought the automated external defibrillation (AED) machine with her to Resident #1's room, said she did not use the AED on him/her. Nurse #2 said she did not call a Code Blue and did not activate 911. Nurse #2 said she left Resident #1's room again, went to another unit downstairs to get help from Nurse #3. Nurse #2 said it took 20 minutes for Nurse #3 to respond from the time Resident #1 was found unresponsive. Nurse #2 said she did not use the intercom because she did not want many staff members to crowd up in Resident #1's room, who was a suspected to have Covid-19. Nurse #2 said the Physician told her to follow the Facility's protocol and gave an order for [REDACTED].M., the Physician said he received a call from Nurse #2 on [DATE], (exact time unknown), that Nurse #2 said Resident #1 was found with no vital signs and that he/she was dead. The Physician said Nurse #2 told him that Resident #1 was a Do Not Resuscitate (DNR). The Physician said he told Nurse #2 to follow the Facility protocol and gave an order for [REDACTED].#1 had already been pronounced dead. During an interview on [DATE] at 2:50 P.M., DON #2 said Nurse #2 called him on [DATE] sometime after the start of 11:00 P.M. to 7:00 A.M. shift (exact time unknown) and said that Resident #1 was found unresponsive, without vital signs, and said that the Physician had given an order for [REDACTED]. Review of Nurse #3's written Witness Statement, dated [DATE], indicated that Nurse #3 was on a different unit when Resident #1 was found unresponsive. The Statement indicated that at some time after 12:00 A.M., Nurse #2 approached her (Nurse #3) on her unit to report that Resident #1 was found unresponsive. The Statement indicated that she (Nurse #3) asked Nurse #2 if Resident #1 was a Full Code and whether they needed to start CPR, but that Nurse #2 told her (Nurse #3) that she already spoke with the Physician who had ordered an RN pronouncement. Nurse #3 said when she asked if there was anything she could do to help, Nurse #2 said she was only waiting for an RN to pronounce Resident #1 dead. During an interview on [DATE] at 1:50 P.M., Nurse #3 said on [DATE] at 12:00 A.M., Nurse #2 came to her unit to inform her that Resident #1 was found unresponsive. Nurse #3 said she immediately asked Nurse #2 if he/she was a Full Code and Nurse #2 said the Physician had already given order for an RN Pronouncement. Nurse #3 said she went to Resident #1's room, assessed that his/her extremities were cold and mottled, that he/she had no pulse, no respirations and no response from sternal rubs. Nurse #3 said she asked Nurse #2 if there was anything she could help with, Nurse #2 said no, and said that she returned to her unit. Nurse #3 said she did not receive a call from Nurse #2 or hear a page for a Code Blue. During an interview on [DATE] at 9:20 A.M. CNA #1 said that at the start of the 11:00 P.M. to 7:00 A.M. shift (exact time unknown) while doing her initial resident care rounds, she heard Nurse #2 say there is a code. CNA #1 said she saw Nurse #2 take the code cart and AED machine into Resident #1's room. CNA #1 said Nurse #2 instructed her to use an Ambu bag to give two rescue breaths while Nurse #2 did about 30 chest compressions. CNA #1 said that Nurse #2 asked CNA #2 to page a Code Blue using the intercom system and that CNA #2 said that she did not know how to use the intercom system. During an interview on [DATE] at 8:20 A.M., CNA #2 said she was the assigned CNA for Resident #1 on [DATE]. CNA #2 said shortly before midnight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225239	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATTLEBORO HEALTHCARE	27 GEORGE STREET ATTLEBORO, MA 02703

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 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) (exact time unknown), Nurse #2 found Resident #1 unresponsive. CNA #2 said she saw Nurse #2 take the code cart and head toward Resident #1's room. CNA #2 said she knew how to call a Code Blue and how to activate 911, but said she was not instructed by Nurse #2 to do so. Review of Resident #1's Nurse Progress Notes, dated [DATE] at 03:04 A.M. and at 10:11 A.M. written by Nurse #2 indicated that Resident #1 was deceased , and that Nurse #2 performed a sternal rub and administered [MEDICATION NAME] spray to both nostrils but that these interventions were ineffective. Review of Resident #1's Medical Record indicated there was no documentation to support that Nurse #2 initiated a Code Blue, performed CPR appropriately according to American Heart Association (AHA) Guidelines, used the AED machine, or activated 911, after finding Resident #1 unresponsive. Review of the RN Pronouncement of Death Report, indicated that Resident #1 was pronounced dead on [DATE] at 9:10 A.M., over nine hours from the time he/she was found unresponsive and without vital signs.
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 records reviewed and interviews for one of eight sampled residents (Resident #1), whose advanced directives indicated he/she was an Attempt Resuscitation (in the event of cardiac or respiratory arrest, attempts at resuscitation will be initiated) and Transfer to Hospital, the Facility failed to ensure staff provided basic life support, including cardiopulmonary resuscitation (CPR) in accordance with the resident's advanced directives and physician's orders [REDACTED].#2, who was a Licensed Practical Nurse (LPN) and CPR certified, found Resident #1 unresponsive, failed to perform CPR correctly, failed to initiate a Code Blue and failed to activate 911. - At 11:40 P.M., Nurse #2 found Resident #1 unresponsive, with no pulse, no respirations and his/her lower extremities were cold with the presence of mottling (mottled skin, before death, presents as a red or marbled appearance) to his/her skin. Nurse #2 gave only three chest compressions, stopped and then left Resident #1 alone to go get help. - At 11:50 P.M., Nurse #2 called the Physician and reported that Resident #1 was unresponsive, was absent of vital signs and reported incorrectly that Resident #1 was a Do Not Resuscitate (DNR) code status. The Physician based on this information, instructed Nurse #2 to follow Facility protocol and then gave an order for [REDACTED].M, despite getting a physician's orders [REDACTED].#2 returned to Resident #1's room with the code cart accompanied by Certified Nurse Aide (CNA) #1 and CNA #2 and attempted to perform CPR on him/her. Nurse #2 gave two sets of chest compressions while CNA #1 gave two rescue breaths with an Ambu bag (an artificial manual breathing unit). Nurse #2 then administered [MEDICATION NAME] (can treat narcotic overdose in an emergency situation) spray in both nostrils. Although Nurse #2 brought the automated external defibrillation (AED, an electronic device that automatically [DIAGNOSES REDACTED].#1. There was no page for Code Blue with the intercom system and 911 was not called. - At 12:00 A.M., Nurse #2 again stopped CPR on Resident #1, left her unit and went downstairs to another nursing unit to request help with Resident #1 from Nurse #3. Findings include: Review of the Facility's Emergency Procedure-Cardiopulmonary Resuscitation Policy, dated ,[DATE], indicated that, if an individual (resident, visitor, or staff) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR shall initiate CPR unless it is known that a Do Not Resuscitation (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual. Resident #1's Advance Directives, documented on a Massachusetts Medical Order of Life Sustaining Treatment (MOLST) Record, dated [DATE], indicated Resident #1's code status included to Attempt Resuscitation (CPR), Use Non-Invasive Ventilation and Transfer to Hospital. Resident #1's [DIAGNOSES REDACTED]. Review of Nurse #2's written Witness Statement, dated [DATE], indicated that she (Nurse #2) found Resident #1 unresponsive to touch and voice, had no respirations, no blood pressure and that his/her extremities were cold, pale and mottled. The Statement indicated that she (Nurse #2) performed a sternal rub, administered [MEDICATION NAME] and contacted the Physician who ordered an RN Pronouncement and for the body to be released to the funeral home. During interviews on [DATE] at 9:10 A.M. and on [DATE] at 12:00 P.M., Nurse #2 said she found Resident #1 unresponsive with no pulse and no respirations in bed during her routine rounds on [DATE] at 11:40 P.M. Nurse #2 said she did three chest compressions, stopped and went to get help. Nurse #2 said she yelled out for Certified Nurse Aide (CNA) #1 and CNA #2 that Resident #1 was unresponsive and said that she went to the nurse's station and made calls to Nurse #3, the Physician, the Administrator and the Director of Nurses (DON) before taking the code cart to Resident #1's room. Nurse #2 said it took five to ten minutes before she could return to Resident #1's room to resume CPR on him/her. Nurse #2 said she did bring the automated external defibrillation (AED) machine into Resident #1's room with her, but said she did not use the AED on him/her. Nurse #2 said she did not call a Code Blue and did not activate 911. Nurse #2 said she left Resident #1's room again, went to another unit downstairs to get help from Nurse #3. Nurse #2 said it took 20 minutes for Nurse #3 to respond from the time Resident #1 was found unresponsive. Nurse #2 said she did not use the intercom because she did not want too many staff members to crowd up in Resident #1's room, who was a suspected to have Covid-19. Nurse #2 said the Physician told her to follow the Facility's protocol and gave an order for [REDACTED].M., the Physician said he received a call from Nurse #2 on [DATE], (exact time unknown), that Nurse #2 said Resident #1 was found with no vital signs and that he/she was dead. The Physician said Nurse #2 told him that Resident #1 was a Do Not Resuscitate (DNR). The Physician said he told Nurse #2 to follow the Facility protocol and gave an order for [REDACTED].#1 had already been pronounced dead. The Facility's Investigation Report, dated [DATE], indicated that Nurse #2 did not review Resident #1's Medical Orders for Life Sustaining Treatment (MOLST) information at the time of the incident, and that Nurse #2 did not accurately report the correct MOLST information to the Physician. Review of Nurse #3's written Witness Statement, dated [DATE], indicated that she (Nurse #3) was on a different unit when Resident #1 was found unresponsive. The Statement indicated that at some time after 12:00 A.M., Nurse #2 approached her (Nurse #3) on her unit to report that Resident #1 was found unresponsive. The Report indicated that she (Nurse #3) asked Nurse #2 if Resident #1 was a Full Code and whether they needed to start CPR, but that Nurse #2 told her (Nurse #3) that she already spoke with the Physician who had ordered an RN pronouncement. Nurse #3 said when she asked if there was anything she could do to help, Nurse #2 said she was only waiting for an RN to pronounce Resident #1 dead. During an interview on [DATE] at 1:50 P.M., Nurse #3 said on [DATE] at 12:00 A.M., Nurse #2 came to her unit to inform her that Resident #1 was found unresponsive. Nurse #3 said she immediately asked Nurse #2 if he/she was a Full Code and Nurse #2 said the Physician had already given order for an RN Pronouncement. Nurse #3 said she went to Resident #1's room, assessed that his/her extremities were cold and mottled, that he/she had no pulse, no respirations and no response from sternal rubs. Nurse #3 said she asked Nurse #2 if there was anything she could help with, Nurse #2 said no, and said that she returned to her unit. Nurse #3 said she did not receive a call from Nurse #2 or hear a page for a Code Blue. During an interview on [DATE] at 9:20 A.M. CNA #1 said that at the start of the 11:00 P.M. to 7:00 A.M. shift (exact time unknown) while doing her initial resident care rounds, she heard Nurse #2 say there is a code. CNA #1 said she saw Nurse #2 take the code cart and AED machine into Resident #1's room. CNA #1 said Nurse #2 instructed her to use an Ambu bag to give two rescue breaths while Nurse #2 did about 30 chest compressions. CNA #1 said that Nurse #2 asked CNA #2 to page a Code Blue using the intercom system and that CNA #2 said that she did not know how to use the intercom system. During an interview on [DATE] at 8:20 A.M., CNA #2 said she was the assigned CNA for Resident #1 on [DATE]. CNA #2 said shortly before midnight (exact time unknown), Nurse #2 found Resident #1 unresponsive. CNA #2 said she saw Nurse #2 take the code cart and head toward Resident #1's room. CNA #2 said she knew how to call a Code Bell and how to activate 911, but said she was not instructed by Nurse #2 to do so. Review of Resident #1's Nurse Progress Notes, dated [DATE] at 03:04 A.M. and at 10:11 A.M. written by Nurse #2 indicated that Resident #1 was deceased , and that Nurse #2 performed a sternal rub and administered [MEDICATION NAME] spray to both nostrils but that these interventions were ineffective. Review of Resident #1's Medical Record indicated there was no documentation to support that Nurse #2 initiated a Code Blue, performed CPR correctly, used the AED machine, or activated 911, for Resident #1 after she found him/her unresponsive, with no pulse, no respirations, despite Resident #1's advanced directives and physician's orders [REDACTED]. Review of the RN Pronouncement of Death Report, indicated that Resident #1 was pronounced dead on [DATE] at 9:10 A.M., over nine hours from the time he/she was found unresponsive and without vital signs.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for eight of eight sampled residents (Resident #1, Resident #2, Resident #3,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225239	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATTLEBORO HEALTHCARE	**27 GEORGE STREET ATTLEBORO, MA 02703**

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8), the Facility failed to ensure that a standing order for the administration of [MEDICATION NAME] (can treat narcotic overdose in an emergency situation) was accurately documented in accordance with professional standards and practices and/or that a resident's clinical record contained a standing order for the administration of [MEDICATION NAME], in accordance with facility policy. Findings include: During interview at 9:43 A.M. on 09/04/20 and throughout the dates of survey, Director of Nurses (DON) #1 said the physician order [REDACTED].#1 said the [MEDICATION NAME] order did not include information including instructions or parameters for use, or any assessments that should be made prior to or after the administration of the medication. The Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, titled Accepting, Verifying, Transcribing and Implementing Prescriber Orders, revised 04/11/18, indicated that important considerations that must be included in all standing orders/protocols included, but were not limited to: - Inclusion/exclusion criteria that the nurse will assess for before administering the substance or activity; - Specification of the details of patient presentation (subjective signs and symptoms); and, - As appropriate to the situation and setting, delineation under what circumstances the substance and/or activity is to be administered including, but not limited to: specific medication dosing instructions based upon specific diagnostic biophysical marker parameters (e.g., signs and symptoms of overdose). The Food and Drug Administration (FDA) Dosage and Administration instructions for [MEDICATION NAME], issued 09/2019, included, but were not limited to: - Administer a single spray of [MEDICATION NAME] Nasal Spray intra-nasally (into the nostril) into one nostril; - Administer additional doses of [MEDICATION NAME] Nasal Spray, using a new nasal spray with each dose, if the patient does not respond or responds and then relapses into respiratory depression; - Additional doses of [MEDICATION NAME] Nasal Spray may be given every two to three minutes until emergency medical assistance arrives. Review of the Order Summary Reports for Resident #1's orders as of 03/01/20, and Resident #2's and Resident #5's orders as of 07/01/20 and, the Medication Review Reports for Resident #4 dated for on or after 08/11/20, for Resident #6 and Resident #7 dated for on or after 09/01/20, and for Resident #8 dated for on or after 09/09/20 indicated that they included medications which appeared in the following order: 1. [MEDICATION NAME] Liquid 4 MG (milligrams)/0.1ML (milliliter) ([MEDICATION NAME] HCl) 0.1 ml in nostril as needed for opioid depression in alternate nostril from first dose, if no response from first dose; and, 2. [MEDICATION NAME] Liquid 4 MG/0.1ML ([MEDICATION NAME] HCl) ml in nostril as needed for opioid depression. There was no documentation to support that the orders included the frequency and duration if appropriate; any necessary patient assessments prior to or after administration of the medication; directions for use, including any cautionary statements required. B. The Facility's [MEDICATION NAME] Use Policy, last revised 11/2017, indicated that standing orders would be obtained for residents as necessary for [MEDICATION NAME] use for the resident found to be exhibiting signs and symptoms of opioid overdose and/or those residents with opioid overuse history. Review of Resident #3's Order Summary Report for orders as of 03/01/20 indicated that it did not include a standing order for the administration of [MEDICATION NAME]. There was no documentation to support that Resident #3's clinical record contained a standing order for the administration of [MEDICATION NAME], in accordance with Facility policy.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on records reviewed and interviews, the Facility failed to maintain a quality assessment and assurance (QAA) committee which consisted at a minimum of the Director of Nurses (DON), the Medical Director or his/her designee, and at least three other members of the facility's staff, and which met at least quarterly and as needed to identify issues with respect to which QAA activities were necessary. Findings include: Review of the Facility's Quality Assurance Performance Improvement (QAPI) policy, dated as last revised in 06/2019, indicated that the QAPI Steering Committee would meet monthly. The Policy also indicated that the Committee members must include the Medical Director, whose attendance was required quarterly. 1. Review of the Facility's Quality Assurance and Performance Improvement (QAPI) committee meeting minutes, dated from 08/28/19 through 08/27/20, indicated that there were no meetings held between May 2020 and August 2020, a period of four months. The Minutes included attendance sheet, dated 05/21/20, with a handwritten notation indicating it was for April 2020. During interview at 7:18 A.M. and throughout the day on 09/16/20, Administrator #1 said that a handwritten notation on the attendance sheet dated 05/21/20 indicated the sheet was for a QAPI meeting held in April 2020. Administrator #1 said he could not locate documentation to support that QAPI meetings were held in May 2020, June 2020, or July 2020. 2. The QAPI attendance sheets indicated that the Medical Director or her designee did not attend any meetings between 01/29/20 and 08/27/20, a period of seven months. There was no documentation to support that the Facility's QAPI committee met at least quarterly, or that the Medical Director or her designee attended meetings at least quarterly.