STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305052	A. BUILDING _____ B. WING _____	**04/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIDGEWOOD CENTER, GENESIS HEALTHCARE	**25 RIDGEWOOD ROAD BEDFORD, NH 03110**

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 record review and interview, the facility failed to provide Cardiopulmonary Resuscitation basic life to a resident requiring such emergency care to 1 resident in a survey sample of 3 residents who expired at the facility. (Resident identifier is #1.) Findings include: Review on [DATE] of Resident # 1's physician orders [REDACTED]. Interview on [DATE] at approximately 12:57 p.m. with Staff C (Social Worker) revealed Staff C arrived at the facility on [DATE] at 8:00 a.m. and was informed that Resident # 1 had expired. Staff C asked what hospital Resident # 1 went to and Staff E (Registered Nurse/Supervisor) stated that Resident # 1 was a DNR (Do Not Resuscitate). Staff C asked to be shown the DNR order. Staff E looked in Resident # 1's medical record and was unable to find an order for [REDACTED]. Interview on [DATE] at approximately 2:30 p.m. with Staff A (Administrator) revealed that Staff A completed an investigation and that on [DATE] Staff F (Licensed Nursing Assistant (LNA)) checked on Resident # 1 who spoke to Staff F briefly and then became unresponsive. Staff F called for Staff D (Licensed Practical Nurse/Charge Nurse) who then assessed Resident # 1 for pulse and found none. Staff D then left the room to get a stethoscope and returned to complete assessment, and noted no heart beat present. Staff D then left the room to obtain Resident # 1's code status. Staff D was at the nurses station when Staff E RN (Registered Nurse Supervisor) arrived on the floor and checked Resident # 1's medical record for code status and stated that Resident #1 was a DNR. Interview on [DATE] at approximately 9:00 a.m. with staff F (LNA) who stated that at approximately 4:45 a.m. Staff F checked on Resident # 1 who spoke briefly and then became unresponsive. Staff F then checked Resident # 1's pulse and respirations and none were present so Staff F notified Staff D who assessed for pulse and then left the room to get a stethoscope. Staff D returned with the stethoscope and completed assessment and then left the room and did not return. Staff F stated that then Staff E pronounced the death of Resident # 1 and at approximately 6:00 a.m. Staff F returned to Resident # 1's room and provided post mortem care. Review on [DATE] of the facility policy titled Cardiac and/or Respiratory Arrest dated [DATE] in the section titled POLICY: states that: Centers support the right of every patient to accept or decline cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. The policy further states that; If a patient does not have a DNR order, CPR/AED certified staff will initiate CPR/AED and emergency medical services (EMS) will be activated. Interview with [DATE] at approximately 2:00 p.m. with Staff E revealed Staff E returned from break to find Staff D sitting at the nurse's station. Staff D told Staff E that Resident #1 had passed away. Staff E checked the code status for Resident #1 in the electronic medical record read that Resident #1's code status was DNR. Staff E later reviewed the chart with Staff C and saw that Resident #1 was a full code. Staff E stated that they must have been looking in the wrong chart. Interview on [DATE] at approximately 2:45 p.m. with Staff D revealed that Staff E looked in the chart and told Staff D that Resident #1 had DNR as a code status. Staff D was not willing to comment further.

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.