STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525363	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAY AT SURING HEALTH AND REHAB CENTER (THE)	430 MANOR DR SURING, WI 54174

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** - Minimal harm or potential for actual harm **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 did not ensure resident code status wishes were followed for 1 Resident (R) (R1) of 2 residents sampled for death at facility. R1's Emergency Care Do Not Resuscitate (DNR) Order was signed by R1's Power of Attorney for Healthcare (POAH) on [DATE] but was not signed timely by R1's physician. R1 received Cardiopulmonary Resuscitation (CPR) on [DATE] against the wishes of R1's POAH. R1 passed away at the facility on [DATE]. Findings include: On [DATE], Surveyor reviewed the medical record of R1. R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. hypertension (high blood pressure). R1 passed away at the facility on [DATE]. R1's medical record contained a nursing note dated [DATE] which stated, Right before 0700 (7:00AM) staff came to writer stating that they think (R1) was not breathing any more. Resident was in the middle of (R1's) shower. Prior to shower resident was per (R1's) usual. Writer entered the shower room and noted resident was aganol breathing (a distinct abnormal pattern of breathing characterized by gasping, labored breathing). Writer auscultated (listened with stethescope) heart and no rate or rhythm noted. B/P (blood pressure) was also not present and O2 (oxygen) sat (saturation level) would not read. Staff assisted resident to room and put resident onto the floor. Back board was placed, writer reassessed for pulse, pulse remained absent and writer instructed (staff name) MT (medication technician) to start compressions as resident was a full code, writer getting ambu-bag (a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing) ready when (social worker name) the social worker entered after (social worker) called the resident's (spouse) and indicated that (spouse) activated POA (Power of Attorney) wants (R1) to be DNR and paper is signed. Compressions were held. Writer reassessed heart and pulse was still absent but resident was still breathing. Pupils were not reactive. Writer had staff assist resident into bed and writer reassessed once more and during this time pulse was still absent but after 15 seconds faint heartbeat returned. Resident was noted to swallow. Staff dressed resident and positioned resident for comfort. Writer called (physician name) and updated (physician) on the events and obtained verbal order for DNR at 0719 (7:19AM) . Further, R1's medical record contained a document titled Emergency Care Do Not Resuscitate Order which was signed by R1's POAH on [DATE]. This document contained a hand-written note at the top which stated, Verbal Order [DATE] 0719 (7:19AM) NJ and the document was signed by R1's attending physician with a date of [DATE]. Surveyor reviewed investigation documents provided by facility which stated, DNR paperwork did not get signed by the doctor. Doctor has not been in house related to COVID-19 (a mild to severe respiratory illness that is caused by a coronavirus and at the time of this situation considered pandemic, meaning worldwide spread). Resident was found with no heartbeat. Chest compressions were started due to not having the signed order for DNR . Social Worker, (social worker name), had terminated (social worker's) employment and was finishing out (social worker's) notice . (Social worker's name) admitted ly said it was (social worker's) mistake. (New social worker's name) was educated on the importance of having the form signed on the day of admission as well as sending it to the doctor to be signed on that day. On [DATE], Surveyor interviewed Director of Nursing (DON)-B via telephone. DON-B indicated DON-B was the nurse working on duty [DATE]. DON-B indicated facility process for obtaining Code Status (whether or not a person wants CPR or to be DNR) orders should be done on admission and that Code Status is listed in facility's Electronic Medical Record (EMR) for staff access. DON-B indicated that Certified Nursing Assistant (CNA)-D came and got me and R1 was in the shower chair when DON-B entered shower room on the morning of [DATE]. DON-B indicated R1 was moved to R1's room because DON-B was having a hard time assessing due to humidity and (R1) was still breathing. DON-B indicated R1's room was a few doors down from shower room and DON-B was able to get complete assessment there. DON-B indicated only four chest compressions were done before Social Worker came in the room and told staff spouse wanted R1 to be DNR. On [DATE], Surveyor interviewed CNA-C via telephone. CNA-C indicated R1 was acting normal but weak the morning of [DATE] prior to R1's shower. CNA-C indicated CNA-D assisted CNA-C with starting R1's shower. Both CNA's were in the shower room with R1. CNA-C indicated CNA-C left briefly to get towels and upon return noted R1 wasn't (R1's)-self and that R1 went limp. CNA-C indicated CNA-D went to get the Director of Nursing (DON). DON came into shower room, assessed R1 and all three took R1 back to R1's room. On [DATE], Surveyor interviewed CNA-D who indicated R1 was squirming in the shower chair so CNA-D called CNA-C to assist with shower process. CNA-D indicated R1 was acting per R1's usual through shower then, while getting R1 dressed after shower in shower room, CNA-C noted R1 wasn't right. CNA-D indicated R1 wasn't breathing very well, wasn't helping with the dressing process like R1 usually did. CNA-D indicated CNA-D left to get DON-B who came with CNA-D back to the shower room. DON-B checked R1's vital signs and they all took R1 to R1's room. That is where staff placed R1 on the floor and staff started CPR. On [DATE], Surveyor interviewed DON-B who verified facility process for obtaining DNR order for R1 was not followed as expected. DON-B indicated DON-B did obtain verbal DNR order from physician via telephone immediately following the above incident on [DATE].
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility did not ensure treatment and care in accordance with professional standards of practice for 1 Resident (R) (R5) of 5 sampled residents. On 7/7/20, facility staff did not respond timely to R5's call light during Surveyor observations. Findings include: On 7/7/20, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]., chronic heart failure (occurs when your heart muscle doesn't pump blood as well as it should), [MEDICAL CONDITION] (gradual loss of kidney function), gout (a type of arthritis that causes inflammation of joints due to excess uric acid) and [MEDICAL CONDITION] (a serious health condition that results from abnormally high excess body fat to an extent that it has a negative effect on health). On 7/7/20 at 9:21AM, Surveyor observed the call light for R5's room was on upon Surveyor's entrance into that facility hallway. During continuous observation, Surveyor observed several facility staff from various departments walk past R5's room without checking on the residents in that room. At 9:53AM, Surveyor observed Certified Nursing Assistant (CNA)-D respond to call light in R5's room, 32 minutes after Surveyor had started continuous observation of R5's call light being on. On 7/7/20 at 10:07AM. Surveyor interviewed CNA-D who indicated R5 was on the commode and was assisted back to bed by CNA-D. CNA-D did not know what time R5 was placed on the commode. CNA-D indicated R5 did not say anything to CNA-D during cares provided regarding how long R5 was sitting on commode. On 7/7/20 at 10:15AM, Surveyor interviewed R5 who indicated typical wait time to have R5's call light answered is 45 minutes to an hour. R5 further stated, Not always but usually it's that long. R5 indicated long call light wait times occur on all three shifts. R5 stated, When I first came I talked to someone higher up

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

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) (about long call light wait times) but don't know who. After while I just stopped trying. R5 did not recall who assisted R5 onto the commode or the time R5 was assisted onto commode. On 7/7/20 at 10:35AM, Surveyor interviewed Director of Nursing (DON)-B who verified R5 did need assistance with getting R5's leg off the bed in order to transfer onto commode. DON stated when questioned, Call lights need to be answered in a timely manner, at least check on the resident to see what the need is. DON indicated all staff, not just nursing staff, should be responding to call lights. When questioned what DON meant by 'a timely manner' DON stated, I would hope not more than five minutes.