STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325032	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANDIA RIDGE CENTER	2216 LESTER DRIVE NE ALBUQUERQUE, NM 87112

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 -** 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 record review and interview the facility failed to ensure that there was a system in place for the nursing staff to immediately recognize the resident's code status in the electronic medical record; and to also ensure that the paper chart was on the same unit as the resident. This deficient practice affected 1 resident (R #1) out of 10 (R #1, 2, 3, 4, 5, 6, 7, 8, 9 and 10) residents residing in the facility, causing confusion among the nursing staff who was not aware of what R #1's code status was and made an assumption of resident being on hospice resulting in staff not initiating any life saving efforts when R #1 was found to not be breathing. The findings are: A. Record review of the face sheet revealed that resident had been diagnosed with [REDACTED]. (This is not a complete list of diagnosis). B. Record review of a History and Physical (H and P) dated [DATE], indicated the following: The chief complaint indicated that R #1 had failure to thrive. R #1 had returned from the hospital with lower lobe pneumonia and chronic on acute kidney failure along with refusing to eat and drink, and refusing medications. Guardianship for R #1 was also in progress. C. Record review of the nursing progress notes dated [DATE] indicated that R #1 needed to have a guardian in place so the facility could pursue Hospice. R #1 had been her own POA (power of attorney) and there was a full code status that the resident had signed in 2016, before she was unable to make decisions about her medical care. R #1 did not have any family to make those decisions. R #1 had not been eating and was declining. R #1 had been sent to the hospital and returned [DATE] for refusing to eat and drink. D. Record review of the dashboard/facesheet in the EMR (electronic medical record) indicated that no advance directives were listed for R #1. E. On [DATE] at 5:00 pm during an interview with Certified Nursing Assistant (CNA) #1, he stated that (on [DATE]) he went into R #1's room and he saw that she was not breathing. He asked the other CNA, CNA #3 to check to see if she was breathing, and CNA #3 confirmed that she was not. He then went and told the nurse that R#1 was not breathing. Registered Nurse (RN) #2 went down to check and confirmed that she was not breathing and continued to check other vitals. RN #2 asked him if he would go find another nurse who could help her with the process for the paperwork because she wasn't familiar. CNA #1 went up front and found another nurse. LPN #2 came down and was told that R #1 had passed away and that RN #2 needed help with the paperwork. LPN #2 started to look for R #1's chart and they could not find it. He stated that they looked for her chart for a long time and he did not know if they found it. During a follow up interview on [DATE] at 10:55 am with CNA #1, he stated that he is Cardio [MEDICAL CONDITION] Resuscitation (CPR) trained and he would have started CPR for R #1 if he knew her code status. He stated he didn't want to start a code because he wasn't clear what it was. F. On [DATE] at 2:20 pm, during an interview with CNA #3, she stated that the first time she worked that unit, and she had worked on the evening shift. She stated that she could not remember specific times but that she had checked in on R #1 and she was fine, this was sometime after dinner she remembers. CNA #3 had been told that R #1 was on palliative care and had been declining. Then towards shift change around 10 :00 am for CNA's, CNA #1 looked in on her again and he came out of the room and asked me to go check on R #1 because he didn't think she was breathing. CNA #3 stated she went and checked and she wasn't breathing. So they went and told RN #2. RN #2 came down and checked her breathing and vitals and pronounced her dead. CNA #3 stated she did not know R #1's code status and CNA #1 wasn't sure if she was on hospice or not, so they went and got the nurse. G. On [DATE] at 5:39 pm, during an interview with RN #2, she stated that she was told during shift change that R #1 was on palliative care. RN #2 stated that she assumed that R #1 was a DNR. RN #2 stated that when she went to check on R #1 around 10 pm, to see if she was breathing, she wasn't exactly hot or cold, but slightly warm to the touch. She felt like R #1 had not just passed away, that it had been a little awhile. Going down to do vitals on her and to check her pupils etc. She did ask for another nurse to come and assist her because she didn't know the process of how they handled a resident death. She stated LPN #2 came down and asked her about her code status and RN #2 stated that she was already dead and that she had already pronounced her. RN #2 stated that LPN #2 identified that R #1 was a full code and asked her if she had started CPR on her. RN #2 told LPN #2 that she thought that she was on palliative care and was a DNR. RN #2 also stated that she felt like R #1 had not just passed away, that it had been awhile. H. On [DATE] at 1:28 pm, during an interview with Licensed Professional Nurse (LPN) #2, she stated that on the evening (around shift change at 10:00 pm, that R #1 passed, CNA #1 had come to her and asked for her to help the nurse on the back unit. He stated that the nurse in the back needed help. LPN #2 stated that she went right away to the back. When she arrived on the unit she was asked about paper work and the forms that needed to be filed out when there is a death. LPN #2 stated that she went to get R #1's chart but they could not find it. She looked in the EMR at the dashboard and the advance directive was not there either. She had to look further into the EMR to find the code status and when she realized that R #1 was a full code she asked RN #2 whether or not she did CPR on her. LPN #2 stated that RN #2 told her no she didn't because she assumed she was a DNR because she was on palliative care. LPN #2 then stated that she instructed RN #2 to call the CNE to tell him what happened. LPN #2 stated that so much time had passed at this point that there would be no need to start CPR. I. On [DATE] at 4:30 pm, interviews with Center Executive Director (CED), she stated that when she interviewed Registered Nurse (RN) #2 during her investigation, RN #2 stated that she was under the impression that R #1 was on palliative care/hospice (an approach that improves the quality of life of patients who are facing the challenges associated with life-threatening illness). The CED stated that R #1 was not on palliative care or hospice at that time, however, that was something they were looking into for her. The CED confirmed that the paper chart for R #2 was not on the hall that she had been readmitted to on [DATE]. The CED also stated that the advance directive was not on the dashboard/face sheet in the electronic medical record (EMR) for R #1. The CED stated that making an assumption about R #1's code status, the fact that the paper chart was not on the proper hall, and that the code status was not available in Electronic Medical Record (EMR) dashboard was inappropriate and a fail on the part of the facility. She also stated that they immediately started a Program Improvement Plan (PIP) and began making changes right away. J. On [DATE] at 2:15 pm, during an interview with the Interim Center Nurse Executive (CNE), he stated that the code status or advance directive was discontinued when R #1 left the facility to go to the hospital. When R #1 arrived back to the facility on [DATE] she was placed on an admission quarantine unit, not the unit she had been on prior to going to the hospital. A new order was never put in place for her advanced directive upon return to the facility, and because there was no order, then it was never put back on the dashboard/face sheet in the EMR. The Interim CNE also stated that if there is no code status available then it goes back to being a full code. K. On [DATE] at 5:15 pm, during an interview with interim CNE, he stated that from a nursing standpoint RN #2 should have started the code. If you don't know someone's code status, if the chart is not available then it becomes full code. He stated that the CNA's also could have and should have started the code. The CNE also stated that there is no excuse to say I thought this resident was on palliative care and assume they were a do not resuscitate (DNR). At the time of the incident on [DATE] the resident had an advance directive which was full code. The

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0678 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) nursing staff at the facility failed to initiate Cardio [MEDICAL CONDITION] Resuscitation (CPR) when resident was discovered not breathing. The facility investigated this death to find where the failure occurred. The facility implemented changes to prevent another incident like this from occurring again. These changes include the following: 1. Audit for accuracy of all resident records with the Medical Orders for Scope of Treatment, (MOST) form and physician order. 2. Monitor clinical dashboard progress notes for change in condition. 3. Validate current advanced directive with responsible party if discrepancy is found. 4. Validate that care plan is updated. 5. Educate nursing staff to validate code status if there is a decline in condition . 6. Educate staff on documentation form for code situations . 7. Educate licensed nurse staff to check crash cart daily. 8. Validate licensed nurses CPR status and review annually. 9. Medical records and Social Services Department to validate that advanced directives are loaded into Point Click Care (PCC) on same day as admission or change in directive. 10. Medical records to ensure physical chart is on appropriate unit where resident resides. (residents need to quarantine when returning to facility on different unit than unit they reside) 11. Nursing staff are to carry on their person the list of residents and advance directives for the hall they are working on for that shift. During onsite investigation of this complaint it was found that this deficiency had been corrected based upon the following: 1. Confirmation that every current resident had an accurate MOST form, physician orders, care plan updates and monitoring of resident dashboards. 2. Nursing staff were educated on Cardiac/Respiratory Arrest, Carts, AED, and MOST forms. The Inservice covered [MEDICAL CONDITION] P and P's AED checklist, Emergency Cart checklist. MOST forms and code status and the training indicated the following: Must be completed upon admission and readmission. After patient signs MOST form, needs to be placed in Physician's bin which is located in the copy room. Orders must immediately be put into PCC (even without provider signature), Anytime family/resident change MOST form, SSD must be notified and PCC order updated. All staff need to have list of Resident's code status on their person at all times. 3. Surveyors reviewed audit sheets for advance directive admission or readmission. It covered the following areas of resident code status such as: reviewed on admission with responsible party, what the code status is, physician order, DNR consent form if applicable, social services documentation of code status, plan of care code status and if the code status alert was in place. 4. Surveyors confirmed that new admits and LTC residents had code status in chart, on dashboard, uploaded in system and physician order [REDACTED].