STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425106	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER - GREENVILLE EAST	**601 SULPHUR SPRINGS ROAD GREENVILLE, SC 29611**

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 interviews and record reviews, it was determined the facility failed to provide CPR (cardiopulmonary resuscitation) for one (Resident #1) of three sampled residents who expired in the facility within the last six months with a Full Code status. Resident #1 was found unresponsive with no vital signs, and the facility failed to perform CPR in an effort to prevent death for this resident who was a Full Code. Fifty-two residents in the facility had a status of Full Code. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy was related to State Operations Manual, Appendix PP, 483.24 (basic life support and CPR) at a scope and severity of J Past Non-Compliance. On [DATE] at 3:45 PM, the Administrator and Director of Nursing were informed of the Immediate Jeopardy. The Immediate Jeopardy existed [DATE] to [DATE]. Staff interviews, record review, policy review and review of trainings were completed during the survey to verify the immediate corrective actions taken by the facility. There was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance at the time of the survey. Therefore, this deficient practice was cited as Past Noncompliance. The findings included: Resident #1 had [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS), dated [DATE], indicated s/he had been admitted to the facility from an acute care hospital, on [DATE], for rehabilitation services and was expected to be discharged to the community. Resident #1's Brief Interview for Mental Status was 15, indicating s/he was cognitively intact with decision making. A physician's progress note, dated [DATE], documented the resident had been admitted to the facility for rehabilitation after a hospital stay, from [DATE] to [DATE], for a debility secondary to [MEDICAL CONDITION] and heart failure. The progress note documented the resident's code status as Full. Full Code indicates a resident is to be resuscitated (provide CPR) in the event of respiratory or [MEDICAL CONDITION]. A social services progress note, dated [DATE], indicated the resident was a Full Code. A care plan, dated [DATE], indicated the resident desired to be a Full Code. The goal listed in the care plan was, Code status will be honored during stay. Interventions included, In the event of [MEDICAL CONDITION] initiate CPR. A Nurse Practitioner's progress note, dated [DATE] at 6:15 PM, indicated the resident's wishes regarding advanced directives were discussed at length from 6:15 PM to 6:31 PM. The note indicated the benefits and risks of CPR were explained to the resident. The resident verbalized understanding, and she wished to be a Full Code. A physician's progress note, dated [DATE], indicated the resident was experiencing increased anasarca (swelling throughout the body) related to heart failure, [MEDICAL CONDITION], and kidney disease. The note indicated the resident was experiencing poor participation in therapy and that palliative care or hospice would be appropriate. The note indicated labs and a chest x-ray were ordered for [DATE], and the doses for two of her diuretic (water pills to remove fluid from the body) medications had been increased. A nursing progress note, dated [DATE] at 1:45 AM, by Registered Nurse (RN) #1 documented, Resident deceased . No apical pulse, no palpable pulse, or BP (blood pressure). No respirations. Pale skin with mottled hands and feet. O2 NC (oxygen by nasal cannula) removed from nares. Resident status is DNR (Do not resuscitate) per report. A nursing progress note, dated [DATE] at 2:24 AM, by Licensed Practical Nurse (LPN) #1 indicated the resident had been found unresponsive by Certified Nurse Assistant (CNA) #3 and reported to this nurse. The note indicated LPN #1 observed the resident to be unresponsive, partially cyanotic (bluish or purple discoloration), and with no respirations or chest movement indicating breathing. The report indicated the resident's pulses could not be detected after one minute of listening. The report indicated the time of death was 1:45 AM, and the family was notified at 2:00 AM. A physician's telephone order, dated [DATE] at 2:00 AM, indicated the physician had been notified, and the body could be released to the funeral home. An initial incident report, dated [DATE] at 3:30 AM, indicated a reportable event involving Resident #1. The report indicated a licensed nurse had failed to provide CPR to Resident #1, who had been found unresponsive with no pulse and no respirations. The report indicated a full investigation had been started. A five-day incident report, dated [DATE], indicated the resident had last been observed, on [DATE] at 11:15 PM, in a stable condition and then was found unresponsive, about two hours later, on [DATE] at 1:15 AM. The report indicated both nurses in the room observed the resident unresponsive with no pulses, no respirations, and mottled (spots or patches of color) arms and dark purple hands. The report indicated the physician was notified at 2:15 AM, and the family was also notified. The report documented LPN #1 was suspended and an investigation was started. A statement of the incident from the facility's investigation by LPN #2, dated [DATE], indicated the resident kept removing her [MEDICAL CONDITION] (Continuous Positive Airway Pressure) machine from her face on the 3 PM to 11 PM shift, and this had been reported to the oncoming nurse, LPN #1. A statement of the incident from the facility's investigation provided by LPN #1, dated [DATE], indicated at 11:20 PM, the resident was easy to awaken by touch and calling her/him name, and s/he went back to sleep after waking. However, the report indicated during the next round at 1:30 AM, the resident was found unresponsive, her/his mouth was open, her facial skin was cyanotic, her/his skin was mottled, her extremities were cold, and a pulse could not be found. The report indicated while CNA #3 stayed with the resident, LPN #1 referred to the resident's chart to determine the resident's code status. LPN #1 found a DNR (Do Not Resuscitate) form at the front of the resident's chart in a plastic sleeve. The statement documented, no CPR performed as DNR status. The time of death was 1:45 AM. After the family arrived at the facility at approximately 2:30 AM, they informed LPN #1 the resident was a Full Code. The report indicated LPN #1 notified the Administrator of the event at that time. A statement of the incident from the facility's investigation provided by RN #1, indicated s/he was called by CNA #2 to come to the 400 unit real quick. When s/he arrived at the resident's room, CNA #3 was in the room trying to obtain vital signs, was unsuccessful, and stated the resident was gone. S/he asked LPN #1 if the resident was a DNR, and s/he said, Yes. S/he tried to obtain a carotid pulse, an apical pulse, and respirations for over one minute, and there were none. The resident had mottled (bluish/purple covered) arms and both hands were purple. S/he returned to his unit, but at approximately 3:00 AM, LPN #1 called him stating the resident had been a Full Code. S/he stated the nurse from the prior shift had told herhim the resident was a Full Code. A statement from the facility's investigation provided by CNA #2, indicated she was at the nurses' station when CNA #3 reported to LPN #1 the resident was not breathing. CNA #2 retrieved the resident's hard chart and sat it on top of the desk, anticipating LPN #1 would need it. LPN #1 asked her/him to tell RN #1 to come assist. The statement indicated CNA #2 asked LPN #1 if the resident was a Code, and s/he was told the resident was a DNR. A statement from the facility's investigation provided by CNA #3, indicated s/he began making her rounds of the unit at 11:10 PM, and the resident was breathing, and her/his chest was moving. At 1:15 AM, the resident was discovered pale, her fingertips were blue, and s/he did not respond when her name was called. S/he reported this to LPN #1, and LPN #1 was unable to get a pulse reading from the resident or an oxygen saturation rate. CPR was not started because LPN #1 thought the resident was a DNR. The statement further indicated staff did not realize, until learning from the family later, that the resident had a Full Code status. On [DATE] at 8:58 AM,

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Resident #1's family member was asked the code status of the resident. The family member stated the resident desired to be a Full Code. On [DATE] at 11:46 AM, the Administrator was asked if Resident #1 had a DNR status. S/he stated the resident had a status of Full Code. S/he stated after the incident, the resident's chart was reviewed and a blank DNR form was found in the chart. S/he stated the DNR form found in the resident's chart had not been filled out or signed. S/he stated the facility had been in the process of changing to an electronic medical record (eMR) system, and the first day that system had been fully utilized was on [DATE]. S/he stated under the old process, with records kept in a hard (paper) chart, when Medical Records Staff prepared a hard chart to admit a resident, the blank DNR forms were included in the chart, in case they were needed. With the change to the eMR, staff had been instructed to look in the computer for a resident's code status. She stated all staff, including LPN #1, had been trained on how to use the new eMR system, including where to find the resident's code status. S/he stated LPN #1 should not have referred to the paper chart to find the resident's code status. S/he provided documentation of staff training and the implementation process of the new system. S/he stated LPN #1 had completed orientation to the new eMR system, on [DATE], and should have looked in the computer for the code status, and s/he provided documentation of this training. S/he stated she thought LPN #1 just panicked. S/he stated immediately upon learning of the event, a complete investigation was started. S/he stated the following interventions were started immediately and completed on [DATE]: 1. LPN #1 was re-educated on Emergency Procedures, where to find code status and reporting of changes in a resident's condition. She stated LPN #1 was an agency nurse, was suspended from work, and had not been back to work in the facility. 2. All staff in the building were educated on Emergency Procedures, where to find code status and reporting of changes in a resident's condition. 3. No staff could start a shift until educated on Emergency Procedures, where to find code status and reporting of changes in a resident's condition. 4. All resident paper charts were reviewed and any blank DNR forms were removed from the charts. 5. All resident's code statuses were reviewed to be correct. Documentation of these interventions was provided. S/he stated a related Performance Improvement Project (PIP) was started on [DATE] with a target end date of [DATE]. Documentation of the PIP was provided, and the summary of the root cause documented, Resident's advanced directive for a full code status was not followed and CPR was not implemented, and patient expired. A nurse stated a blank DNR form for patient was on chart. The form indicated the PIP had been successful. On [DATE] at 12:20 PM, the resident's Nurse Practitioner was asked if CPR should have been provided for a resident with a status of Full Code who was found unresponsive, with no pulse or respirations, even if the resident had blue areas on their fingers and toes. S/he stated CPR should have been started on Resident #1 and cyanosis should not play a part in the decision to start CPR at all. On [DATE] at 1:21 PM, CNA #2 was asked why CPR had not been started for Resident #1. S/he stated she asked the nurse if the resident was a Full Code, but LPN #1 stated the resident was a DNR, and so CPR was not started. On [DATE] at 1:26 PM, the Respiratory Therapist, who taught CPR at the facility, was asked if CPR should have been provided for a resident with a status of Full Code who was found unresponsive, with no pulse or respirations, even if the resident had blue areas on their fingers and toes. S/he stated CPR should have been started and a code called for anyone found unresponsive and blue, with no pulse or respirations. On [DATE] at 1:38 PM, LPN #2 stated he took care of Resident #1 on the 3 PM to 11 PM shift on [DATE]. S/he stated the resident would take off her [MEDICAL CONDITION], but that was usual behavior for the resident, and s/he reported it to the oncoming nurse. He stated the resident had been declining slowly ever since she had arrived at the facility. S/he was asked if the resident had experienced a change of condition since the doctor had seen her/him that afternoon, and he said, No. S/he was asked what the code status was for the resident, and s/he stated s/he had been a Full Code. On [DATE] at 2:02 PM, LPN #1 was asked why Resident #1 did not receive CPR. S/he stated the nurse from the prior shift had told her the resident was a DNR during the nursing report given to her at shift change. S/he stated when CNA #3 told her/him the resident was not breathing, s/he checked the resident's chart and saw a DNR form. S/he stated she thought the resident's status was DNR, so s/he did not start CPR. S/he indicated s/he could not find the orders in the paper chart. S/he stated it was only after the family told her Resident #1 was a Full Code that s/he rechecked the DNR form in the chart, and saw it was blank and not filled out. S/he stated s/he was a relatively new nurse, and this was the first time s/he had ever had a patient expire on her/his shift. On [DATE] at 2:15 PM, CNA #3 was asked why CPR had not been provided to the resident. S/he stated s/he asked the nurse if s/he should start CPR, but LPN #1 told her/him the resident was a DNR. S/he stated LPN #1 looked in the book (hard chart) and said it had a DNR form. CNA #3 said, Come to find out, nobody had signed that form. S/he (LPN #1) honestly thought the resident was DNR. CNA #3 stated LPN #1 was very upset to learn the resident was a Full Code. The facility's Plan of Correction documented: This Plan of Correction serves as Heartland Health Care Center of Greenville East's response to the Immediate Jeopardy notification that the center received [DATE] at 15:45 regarding tag F678. The center does not admit nor concede the citations cited in the Notification. However, to the extent that any legitimate deficiencies exist at the Center, the Center is taking appropriate actions to correct any deficiencies that may be present at the center including, that actions listed in the Plan of Correction. The facility took immediate action to resolve the alleged of the facility to provide appropriate care, specifically not ensuring CPR was provided to a resident in an effort to prevent death. - On [DATE], (name redacted), Director of Nursing, reeducated LPN on location of code status in patient's electronic medical record. - On [DATE], (name redacted), Administrator held an ad-hoc QAPI meeting to discuss incident review and immediate corrective action. In addition, the facility took the following actions: Like Residents - All resident charts were audited by social services to validate code status was readily available and correct on [DATE]. Systemic Changes - All resident charts were audited by Medical Records to remove blank EMS DNR and advance directives order form for current charts (if full code) and blank admission packets moving forward, completed on [DATE]. - Administrator reeducated social services on advance directives process to include the complete execution of all appropriate paperwork, signatures and order execution, completed on [DATE]. - Administrator audited 5 random pre-made new admission charts weekly x 4 weeks; initiated on [DATE] completed on [DATE]. - Director of Nursing reeducated all licensed nursing staff and current agency licensed staff, beginning on [DATE] on advanced directives, including code status identification and proper execution of CPR processes and completed all licensed nurses on [DATE]. - Licensed nurses to receive education upon hire, as part of orientation, and annually on advanced directives, including code status identification and proper execution of CPR processes. - Agency staff will receive orientation for education on emergency management, including code status identification and proper execution of CPR processes, prior to receiving initial assignment, beginning on [DATE]. Monitoring - Code status to be reviewed daily in clinical meeting by IDT on all new admits. - Social worker initiated new admission audits on [DATE] to verify code status guidelines are being followed x 3 weeks, completed on [DATE]. - Agency orientation checklist to be reviewed with HR and/or designee, prior to staff working on floor. This plan was reviewed on [DATE]. The facility's corrective actions were reviewed during the survey for validation. Records were reviewed for twelve agency nurses who currently worked in the facility, and they all had received the required training. Records were reviewed for five staff nurses and three CNAs and they all had received the required training. Interviews were conducted with six nurses (RNs/LPNs) and five CNAs. All staff members confirmed ongoing education related to emergency procedures, CPR, and code status determination. Random hard (paper) charts were sampled throughout the facility, and no chart was found to contain a blank DNR form. Resident's code status for five residents was reviewed in the eMR and found to be correct. On [DATE] at 1:30 PM, the Administrator was asked, if a resident has a physician's orders [REDACTED]. S/he said, Yes. A facility policy titled, Cardiopulmonary Resuscitation: Adult, documented: when [MEDICAL CONDITION] occurred CPR was to be initiated unless a valid DNR (Do Not Resuscitate) was in place, initiating CPR could cause injury or peril to the rescuer, or obvious signs of clinical death were present including rigor mortis, decapitation, transection, or decomposition. The policy documented, In all other instances, CPR is to be administered. A facility policy titled, Emergency Management, included Emergency Response Guidelines. These guidelines indicated the first licensed nurse to arrive on the scene would evaluate the resident and direct additional nursing staff to review the chart for living will or DNR documentation, physician orders [REDACTED]. As documentation provided and interviews conducted confirmed all elements of the plan had been implemented, this deficiency was cited as Past Noncompliance.