STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525580	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOWBROOK AT BLOOMER	**1840 PRIDDY ST BLOOMER, WI 54724**

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 interview and record review, the facility failed to provide basic life support, including Cardiopulmonary Resuscitation (CPR), to a resident requiring emergency care and failed to notify emergency medical personnel for 1 of 3 sampled residents (R) R1. R1 was found pulseless and not breathing on [DATE]. R1's Physician order [REDACTED]. Facility failure to begin cardiopulmonary resuscitation and for failing to call 911 created a finding of immediate jeopardy that began on [DATE]. The Nursing Home Administrator (NHA) was notified of the immediate jeopardy on [DATE] at 3:30pm. The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan. This is evidenced by: On [DATE] at 9:00 a.m., Surveyor performed a tour of the facility. An undated sign posted at the nurse's desk read Full code list. The list contained the names of 9 residents. Surveyor interviewed Licensed Practical Nurse (LPN) E, who was the charge nurse for the facility. LPN E told Surveyor that the Full code list is reviewed daily and updated with new admissions. LPN E stated that the Full code list is populated from the computer. LPN E showed Surveyor the listed residents' Medication Administration Records which contained code status listed at the bottom of the document. Surveyor reviewed physician orders [REDACTED]. The Full code list reflected accurate information, as noted in the physician orders [REDACTED]. LPN E told Surveyor that residents' code information is also kept in a binder at the nurse's station for easy access, in case the facility needs to transport a resident to the hospital. The binder was titled Resident Info. Binder. Surveyor reviewed the Resident info. Binder. LPN E told Surveyor that this information is also listed in the computer. Surveyor reviewed and compared residents' physician orders [REDACTED]. Binder. The life sustaining information that was available in the Resident Info. Binder coordinated with residents' POLST information and physician orders. However, not all residents in the facility were included in the binder. Surveyor interviewed LPN J regarding facility teaching/training for CPR. LPN J told Surveyor that she completed Relias (a computer program) training a year or more previous, that was through the last company ownership. The training included: When to initiate CPR, use of the crash cart and emergency notifications. LPN J stated, I am certified in Basic Life Support. At 10:15 a.m., Surveyor reviewed R1's clinical record. R1 was admitted to the facility on [DATE]. R1's [DIAGNOSES REDACTED]. R1's Minimum Data Set (MDS) listed only entrance and exit data. However, R1's cognitive status on admission, [DATE], is documented as alert and oriented, with periods of confusion. The physician order [REDACTED].Resuscitate. Treatment options when the patient/resident has a pulse and or is breathing .Aggressive Treatment: Includes the above and/or endo tracheal intubation .advanced airway and cardiac defibrillation Under the title of Antibiotics the POLST states Aggressive treatment. Progress Notes stated, in part: [DATE], 04:31 p.m.: Resident condition remains stable. VSS (Vital signs stable) at this time. Resident is alert and oriented, cognitive status at baseline. Resident does continue to have episodes of nausea with emesis .Resident condition will continue to be monitored. [DATE], 03:02 p.m.: Resident has been pleasant this shift. No nausea or vomiting today, complainants of pain managed well with prn (as needed) pain medication. Resident PO (oral) intake improving with decreased n/v (nausea and vomiting) .Resident spoke with family on the phone today Resident will continue to be monitored for changes. [DATE], 09:17 p.m.: Resident noted to be increasingly sob (short of breath) and complains of increased pain this evening. Prn [MEDICATION NAME] administered for sob/pain. Call placed to MCHS (Mayo Clinic Health System) Home Health and Hospice. Awaiting reply. This note was written by LPN D. [DATE], 12:35 a.m.: Writer (RN (Registered Nurse) F) alerted by prior shift that resident passed away at 09:55 p.m. on [DATE], prior nurse had contacted family and hospice to update and request processing of the death. RN F is no longer an employee at the facility, and therefore unavailable for interview. At 11:45 a.m., Surveyor interviewed LPN D. LPN D stated that R1 became agitated around the time of bedtime or medication pass. LPN D stated that R1 offered no specific complaints, and was restless, changing positions in bed often. LPN D stated that she assisted R1 with calling his sister by giving him the facility's portable phone. After R1 talked to his sister and prayed, he calmed down. LPN D stated she did not know what time this was, but it was after medication pass. LPN D stated the next time she checked on R1, at an unknown time, but after medication pass, R1 was dead. LPN D confirmed R1 was dead by auscultating his lungs and checking his pulse and blood pressure, which was not registering. LPN D stated R1 was not breathing. LPN D stated CNA G accompanied her into R1's room. Surveyor asked LPN D if CPR was attempted. LPN D stated, No, CPR was not attempted since he was a hospice patient. Surveyor asked LPN D to describe R1's code status. LPN D stated, We knew he was a full code. LPN D stated she had not checked physicians' orders at the time of the incident. Surveyor asked LPN D why she did not document the circumstances surrounding R1's death in the progress notes. LPN D stated, Because I passed that onto the next shift. Asked to describe how CPR information is communicated to staff, LPN D stated, Our DON comes out of her office and gives us updates. I'm not sure if it was on [DATE], but I told her during shift report, while discussing R1's code status This is bizarre. R1 is a hospice patient .What are we supposed to do? LPN D stated DON B told her We are in the process of changing R1's code status to do not resuscitate. LPN D told Surveyor the Full Code List was not posted. LPN D told Surveyor she has had no training through the facility regarding CPR initiation or emergency management when a resident is found pulseless and is not breathing. At 11:48 a.m., Surveyor interviewed DON B. DON B stated no staff had asked her about R1's code status, or interventions for R1 if R1 became breathless or pulseless. At 12:40 p.m., Surveyor interviewed Medical Doctor (MD) G, who is the Medical Director at the facility. MD G stated, If a resident is a full code, I would expect the staff to do CPR. At 1:00 p.m., Surveyor interviewed Social Services Director (SSD) I, who is responsible for coordination of advance directive information for the facility. SSD I stated, I talked to his Power of Attorney for Health Care (R1's sister). R1's sister stated she was aware R1 wanted to be a full code, and she wanted R1's wishes followed. No, I did not document this conversation. It occurred sometime after the resident was admitted . At 1:50 p.m., Surveyor interviewed Certified Nursing Assistant (CNA) H, who was responsible for R1 on [DATE] p.m. shift. CNA H told Surveyor that sometime after medication pass, LPN D assisted R1 in using the portable phone to call his sister. CNA H stated LPN D returned the phone to the charging station, then re-entered R1's room After entering R1's room, CNA H stated LPN D came out of the room and stated, Oh my God, I think he is dead. CNA H stated she was shocked since R1 had just been talking and laughing with the staff after talking to his sister. CNA H told Surveyor LPN D did not begin CPR or issue instructions to CNA H regarding EMS activation. CNA H stated, No, she did not give us any instructions. I didn't see LPN D check R1's pulse or blood pressure or nothing when I went into the room. At 3:45 p.m., Surveyor interviewed Corporate Nurse (CN) C. CN C stated that all nurses are required to be CPR certified. On [DATE], Surveyor received a policy entitled CPR. The facility policy instructs the facility to call a Code Blue for pulseless patients without respirations. The policy states, in part, the resident identified as resuscitate will have CPR begun by a qualified and trained person .each shift is to perform a code blue drill one time per month. The DON will review the results of the drill and inservice as needed. Surveyor interviewed DON B. DON B stated that she could not

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) locate staff training on CPR since she is new and there is new ownership in the facility. DON B stated that the facility is not performing code blue drills, but will do so now. The failure to follow the resident's wishes and provide CPR created a finding of immediate jeopardy. The facility removed the immediate jeopardy on [DATE] when it began implementing the following: *All staff on-site had immediate education clarifying that regardless to a resident being on palliative care or hospice their code status will be followed. *All staff to be educated on where the code status forms are as well as random audits to ensure compliance. *All staff to be educated on code status, to verify code status in the chart and to initiate CPR for full code status residents.