STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235523	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND NURSING CENTER	22401 FOSTER WINTER DR SOUTHFIELD, MI 48075

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure an environment free from neglect for one resident (R#160) of one resident reviewed for abuse/neglect, resulting in R#160 not receiving regular rounding/observations by staff for an extended period of time, staff failing to appropriately act and report on a change of condition and the potential for further unmet care needs. Findings include: On [DATE] the medical record for R#160 was reviewed and revealed the following: R#160 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#160's careplan revealed the following: Problem-I, (R#160), am aware that I need assist with my ADL's (activities of daily living) r\t (related to) Activity Intolerance, External devices (L(left) knee immobilizer), Fatigue, Impaired balance, Limited Mobility s/p (status/post) L patellar fracture .Interventions-Allow sufficient time for dressing and undressing. Requires max A (assist) for LE (lower extremity) dressing, Set-up to min (minimal) A for UE (upper extremity) dressing. Pt. (patient) will work with occupational therapy to utilize AE (all extremities) as recommended, utilize compensatory strategies to facilitate modified independent UE and LE dressing .Requires max (maximum) A for toileting; please encourage use of commode over toilet using wall grab bar. Pt. will work with occupational therapy to improve ADL transfers, improve strength and balance, utilize DME (durable medical equipment) to facilitate modified independent toileting . On [DATE] a facility reported incident/investigation pertaining to R#160 on [DATE] was reviewed and revealed the following: .Monday [DATE] an interdisciplinary team gathered at the usual morning meeting to review the occurrence (R#160's unwitnessed death) at the daily stand-up meeting led by the Director of Nursing (DON) and Administrator in Training (AIT O). After the initial meeting, questions remained about the timeliness of interventions for the code so the investigation continued .On Tuesday, [DATE], Administrator in Training requested the video from security cameras and on Wednesday, [DATE] after review of the security video, AIT and DON presented the findings to HR (Human Resources) and the investigation into the night shift began .On Wednesday late in the day, after reviewing video from the day in question, it was discovered by the DON and AIT that the Certified Nurse Assistant (CNA C) and the on-duty Nurse (Licensed Practical Nurse) (LPN D), who were working the floor prior to the 7:00 AM shift change had gone into the resident room together and walked back out into the hallway together and went their separate ways. Neither personal called for anyone as noted on the video. The two ladies gathered their belongings and walked down the north stairway. During the interview and when presented with this evidence, (CNA C) reported to the DON that she found the resident clearly deceased at approximately 7:15 am and immediately reported it to (LPND) who, after going in the room to verify his condition, told her not to report it. The two of them finished their shift and left the facility .Both (CNA C) and (LPN D) were terminated from their employment after review of the video and written statement from (CNA C). Although both (CNA C) and (LPN D) have current CPR (Cardiopulmonary resuscitation) certificates and have up to date in-servicing on abuse, neglect and elder justice it was determined that neither person chos <sic> initiate CPR on the deceased resident. This is a direct violation of that which they had been trained and licensed to do .In conclusion, although the outcome may not have changed, the night shift CNA (CNA C) and LPN (LPN D) were negligent in their duties. Even though both individuals had been inserviced on abuse and neglect and both had CPR certification up to date both chose to disregard this training. Furthermore, after passing state licensing screenings and have on-call management available for consultation, these individuals chose to act in violation of their licensure and their responsibility to report . A Corrective Action Report for CNA C dated [DATE] revealed the following: Date of Violation-[DATE] .Level-Discharge .Nature of Unacceptable Behavior: On the midnight shift of [DATE] employee failed to complete rounding on her patient (R#160) between the hours of 8:30 PM and 6:50 AM at which time she found the patient deceased .Additionally, while the employee did report her finding to the midnight nurse, she did not elevate her concern when the nurse advised her not to report her finding to anyone else. The two employees proceeded to leave their shift without notifying anyone that the patient was expired . A Corrective Action Report for LPN D dated [DATE] revealed the following: Date of Violation-[DATE] .Level-Discharge .Nature of Unacceptable Behavior: On the midnight shift of [DATE], employee did not complete rounding as necessary on (R#160). Employee failed to properly check patient between approximately 9:00 PM and 7:14 AM. At approximately 7:14 AM the nurse was notified by the PCT (patient care technician) (CNA C) that the patient expired. Nurse then advised the PCT not to tell anyone and they both proceeded to leave for the day at the end of their shift shortly thereafter without informing any that the patient had expired . On [DATE] at approximately 3:12 p.m., during a phone conversation with CNA C, CNA C was queried regarding the incident involving R#160 on [DATE]. CNA C reported they had gone into R#160's room at approximately 6:50 AM and that R#160 appeared deceased . CNA C indicated they came out of the room and informed LPND about R#160. LPN D then went into the room followed by CNA C and LPN D reportedly looked at R#160 and told CNA C we didn't see anything. CNA C was queried if either of them (CNA C or LPN D) performed CPR on R#160 and they indicated they didn't. CNA C then indicated they went into another room to do charting but didn't finish because they were intimidated by LPN D who was in the room with them. CNA C then reported they clocked out and left the building with LPN D. CNA C was queried if they told anyone about R#160's change in condition before the left the building with LPN D and they indicated that they didn't. CNA C was queried why they didn't tell anyone about R#160 and they reported they did not have the DON's phone number and they felt they didn't know the oncoming nurse well enough. On [DATE] at approximately 11:34 a.m., during a conversation with the DON, the DON was queried what LPN D should have done regarding the incident involving R#160 on [DATE]. The DON reported that LPN D should have completed an SBAR form (documentation for an incident including -Situation, Background, Assessment, Recommendation) and ran the code (initiate the CPR process). The DON was queried what CNA C should have done during the incident and they reported that CNA C should have told anyone and everyone. The DON was queried how often facility staff should be doing rounds on their residents and they indicated that it was every two hours. The DON indicated no SBAR from was completed by LPN D regarding R#160. On [DATE] at approximately 12:14 PM, an observation of timed video obtained from the Facility's security system for dates [DATE] (start time -7:00 PM) through [DATE] (end time - approximately 8:00 AM) was conducted with the DON and AIT. The video did not contain audio. The video provided a clear observation of staff entering and exiting residents' rooms on their assigned unit/hall. There was no evidence observed on the video that LPN D entered R#160's room to provide medication, monitoring, assessment, treatment and/or care to R#160 from 7:00 PM through 7:00 AM (12 hours). At approximately 7:14 AM on [DATE] the video indicated that CNA C entered into R#160's room and exited shortly thereafter and approached LPN D. At approximately 7:16 AM, both LPN D and CNA C enter into R#160's room and exited approximately one minute later at 7:17 AM. At 7:45 AM both LPN D and CNA C were observed exiting the unit. * It should be noted that LPN D had initialed in a progress note dated [DATE] (7:02 AM), as noted above, that they had monitored the resident during the evening and the resident appeared alert and oriented. R#160 Medication Administration Record [REDACTED]. There was no evidence on the video that LPN D had entered into the resident's room or

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

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) that the resident was provided medication/treatment at those times. On [DATE] at approximately 1:25 p.m., during a conversation with the facility Administrator (abuse coordinator), the Administrator was queried regarding the conclusion of their investigation into the death of R#160 on [DATE]. The Administrator indicated they substantiated neglect had occurred by CNA C and LPN D after watching the video of the security camera. The Administrator indicated that both staff members (CNA C and LPN D) were supposed to check on their residents every two hours and that they failed to do it was just wrong. On [DATE] at 2:54 PM, an interview was conducted and LPN G was asked about R#160. LPN G explained she wasn't surprised, as LPN D and CNA C were both known as the laziest employees the facility had and staff had complained about them both several times. LPN G further explained that CNA C had started out working days, but had complained about the work load and had transferred to another facility because she thought it would be less work, then transferred back to the facility on midnights. LPN G stated, (CNA C) ran from work. LPN G was asked about LPN D. LPN G explained they had worked at the facility together for several years and stated, You think you know someone, I guess you never do. LPN G further explained that LPN D had started her shift at 7:00 PM, but the only note she had written about R#160 was at 7:00 AM, and that there was nothing true written in the note proved LPN D had lied. LPN G went on to explain the staff worked hard to make it a good facility and that all the staff were upset that two people could destroy all that work by their inaction. On [DATE] a facility document titled Hourly Rounding Process dated [DATE] was reviewed and reveled the following: A team member is expected to have a 'meaningful' round on patients/family every hour (documented) during the day and every two hours in the late evening to allow for patient rest. -Rounds may be 'purposeful' .Hourly rounding logs should be placed inside the patients room preferably requiring the staff to cross the patients line of sight to document the round .If available sit down in an open chair to get eye level with the patient; this practice is proven to increase the patient's perception of the duration of the round .Common practice is to have nurses round on even hours and patient care technicians round on odd hours .hourly rounding should be consistent and measure in order to minimize unanticipated patient call lights or risk for patients falls related to bathroom or proximity needs . Review of a facility policy titled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of resident property revised [DATE] read in part, .Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff . Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .
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 observation, interview and record review the facility failed to initiate Cardiopulmonary Resuscitation (CPR) when a Resident was found unresponsive, and to immediately begin CPR when a Code Blue (unresponsive person) was called for one (R#160) of one Resident reviewed for CPR who had a documented full code status resulting in a Immediate Jeopardy (IJ) when the Resident was found unresponsive with no pulse or respirations. This had the increased likelihood to cause serious injury, harm and/or death. Findings include: The IJ began on [DATE]. The IJ was identified on [DATE]. The Administrator was notified on the IJ on [DATE] at 3:43 PM and a plan to remove the immediacy was requested. The immediacy was removed on [DATE] based on the facility's implementation of an acceptable plan of removal verified on-site by the survey team. Although the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. Review of a Facility Reported Incident (FRI) submitted to the State Agency read in part, .Monday [DATE] an interdisciplinary team gathered at the usual morning meeting to review the occurrence (R#160's unwitnessed death) at the daily stand-up meeting led by the Director of Nursing (DON) and Administrator in Training (AIT O). After the initial meeting, questions remained about the timeliness of interventions for the code so the investigation continued .On Tuesday, [DATE], Administrator in Training requested the video from security cameras and on Wednesday, [DATE] after review of the security video, AIT and DON presented the findings to HR (Human Resources) and the investigation into the night shift began .On Wednesday late in the day, after reviewing video from the day in question, it was discovered by the DON and AIT that the Certified Nurse Assistant (CNA C) and the on-duty Nurse (Licensed Practical Nurse) (LPN D), who were working the floor prior to the 7:00 AM shift change had gone into the resident room together and walked back out into the hallway together and went their separate ways. Neither personal called for anyone as noted on the video. The two ladies gathered their belongings and walked down the north stairway. During the interview and when presented with this evidence, (CNA C) reported to the DON that she found the resident clearly deceased at approximately 7:15 am and immediately reported it to (LPND) who, after going in the room to verify his condition, told her not to report it. The two of them finished their shift and left the facility .Both (CNA C) and (LPN D) were terminated from their employment after review of the video and written statement from (CNA C). Although both (CNA C) and (LPN D) have current CPR (Cardiopulmonary resuscitation) certificates and have up to date inservicing on abuse, neglect and elder justice it was determined that neither person chos <sic> initiate CPR on the deceased resident. This is a direct violation of that which they had been trained and licensed to do .In conclusion, although the outcome may not have changed, the night shift CNA (CNA C) and LPN (LPN D) were negligent in their duties. Even though both individuals had been inserviced on abuse and neglect and both had CPR certification up to date both chose to disregard this training. Furthermore, after passing state licensing screenings and have on-call management available for consultation, these individuals chose to act in violation of their licensure and their responsibility to report . Review of a Corrective Action Report dated [DATE] for CNA C read in part, .Level: Discharge . NATURE OF UNACCEPTABLE BEHAVIOR: On the midnight shift of [DATE] employee failed to complete rounding on her patient (R#160) between the hours of 8:30 PM and 6:50 am at which time she found the patient deceased . Additionally, while the employee did report her finding to the midnight nurse, she did not elevate her concern when the nurse advised her not to report her finding to anyone else. The two employees proceeded to leave their shift without notifying anyone that the patient was expired . The form was signed by the DON on [DATE] and Notified via phone was written on the Employee Signature line, signed by HR Coordinator B and dated [DATE]. A written statement of a phone interview conducted and signed by the DON on [DATE] with CNA C regarding#160's death on [DATE] revealed the following: I am the Director of Nursing at (Name of Facility) and I am writing this statement r/t (related to) second telephone conversation I had with (CNA C) on [DATE]. The Administrator in training present. (CNA C) wanted to talk about the situation r/t the decreased <sic> patient (R#160) and actual conversation she had with the Nurse (LPN D) during report. (CNA C) stated that during her conversation with nurse, that she told the nurse that she thought the patient looked dead. She and the nurse shortly therefore after went into the <sic> and noted that the patient was unresponsive. They did not call for a 'Code Blue' (process of initiating CPR) or tell the oncoming shift who were present on the unit. I asked her why she did not tell the am nurse about the patient unresponsiveness, she stated she does not know her, and she told her nurse. I asked her why did <sic> not to tell anyone so patient care could be initiated; she state <sic> she feared retaliation from her nurse because she has gotten people fired in the past. She stated her and the nurse had a conversation outside in the parking lot whereas per recording (CNA C) states that 'I told you he looks dead to me and that I don't want this to come back on us. A Corrective Action Report for LPN D dated [DATE] revealed the following: Date of Violation-[DATE] .Level-Discharge .Nature of Unacceptable Behavior: On the midnight shift of [DATE], employee did not complete rounding as necessary on (R#160). Employee failed to properly check patient between approximately 9:00 PM and 7:14 AM. At approximately 7:14 AM the nurse was notified by the PCT (patient care technician) (CNA C) that the patient expired. Nurse then advised the PCT not to tell anyone and they both proceeded to leave for the day at the end of their shift shortly thereafter without informing any that the patient had expired . Review of (Name Redacted) Fire Department Patient Care Record documented in part: Assessment Time: [DATE] 08:28:58 (8:28 AM) . Narrative: Dispatched to a code blue (unknown medical) . (R#160) laying in supine (on back) in bed with medical staff performing CPR . We immediately took over CPR . pupils were fixed and dilated . Full ACLS (Advanced Cardiac Life Support) protocol for asystole (no heart contractions) was performed for 37 min when pronouncement was placed . Staff states they possibly last saw him alive during the 0700 (7:00 AM) checks, however staff states they thought he was sleeping and cannot

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) truly state he was alive at that timeframe . A review of R#160 ' s clinical record documented the following: A Basic Care Plan Summary dated [DATE] (14:,[DATE]:05 PM) authored by LPN G documented, in part, the following: I, R#160, was admitted on [DATE]. My [DIAGNOSES REDACTED]. I am cognitively intact .My home diet is regular, .My dentures, partial fit good I am not a diabetic. I do not require [MEDICAL TREATMENT] I prefer choosing the clothes I wear, caring for my personal belongings, receiving a shower, having my family or significant other involve in my care I have adequate hearing, I do not use hearing aid or other hearing appliance. I have adequate vision, I use corrective lenses. I am occasionally incontinent of bowel I am occasionally incontinent of urine .My initial admission goal is Patient stated I want to be able to walk again. My initial discharge goal is to return home. My intended destination is to be discharge home with family. . A progress note dated [DATE] (07:02 AM) authored by LPN D documented, patient is a new admit, alert and oriented x3, denies pain and discomfort, rested well last night, due meds given and well tolerated, reposition every 2 hrs, kept clean and dry, safety maintained, call light and personal items within reach, will continue to monitor. A progress note dated [DATE] (14:,[DATE]:02 PM) and authored by Registered Nurse (RN) F documented, This writer was called to the resident's room @7:50 by assigned (CNA) who stated that resident appeared deceased . This writer went to the room to asses the resident who was noted with no pulse or respiration. The resident's code status was checked, the crash cart was taken to the room and this writer informed the (CNA) to call the 4th floor staff and the security desk again. The 4th floor nurse came into the room with CPR initiated .(name redacted) EMS (emergency medical service) arrived and took over CPR .this writer called (name redacted) Dr .The resident's time of death was notated at 0901 . On [DATE] at approximately 3:12 p.m., during a phone conversation with CNA C, CNA C was queried regarding the incident involving R#160 on [DATE]. CNA C reported they had gone into R#160's room at approximately 6:50 AM and that R#160 appeared deceased . CNA C indicated they came out of the room and informed LPND about R#160. LPN D then went into the room followed by CNA C and LPN D reportedly looked at R#160 and told CNA C we didn't see anything. CNA C was queried if either of them (CNA C or LPN D) performed CPR on R#160 and they indicated they didn't. CNA C then indicated they went into another room to do charting, but didn't finish because they were intimidated by LPN D who was in the room with them. CNA C then reported they clocked out and left the building with LPN D. CNA C was queried if they told anyone about R#160's change in condition before they left the building with LPN D and they indicated that they didn't. CNA C was queried why they didn't tell anyone about R#160 and they reported they did not have the DON's phone number and they felt they didn't know the oncoming nurse well enough. On [DATE] at approximately 4:48 PM a phone call was made to LPN D. LPN D answered the call and did not answer any questions asked. On [DATE] at approximately 4:59 PM, a phone interview was conducted with CNA F. CNA F reported working at the Facility for approximately one year and was CPR certified. CNA F was queried as to the death of R#160. CNA F indicated that they arrived at the Facility on [DATE] to begin the 7 AM to 7 PM shift and as usual protocol they received updates from the night shift CNA. CNA F indicated that the night shift CNA was CNA C who did not express any major concerns with any of the residents, including resident #160. CNA F stated that CNA C told them that they needed to check on R#160. CNA F then stated that CNA C left the facility for the day. CNA F further reported that at approximately 7:45 AM a breakfast tray was brought to the unit and soon after, they entered into the residents room with a breakfast tray and observed that the resident looked purple and their eyes were half closed. CNA F then ran to get RN E who asked that they get a Nurse from the 4th floor and notify security. CNA F reported that she did not start CPR on her own. On [DATE] at approximately 8:45 AM, a phone interview was conducted with RN E. RN E indicated that they were a Registered Nurse that had worked contingent for the Facility for two years and was CPR certified. RN E was then queried as to the death of R#160. RN E reported that they were assigned to work the day shift (7:00 AM to 7:00 PM) on [DATE]. RN E stated that when they arrived at the facility on [DATE] they were updated by LPN D as to the residents residing at the Facility. RN E indicated that nothing significant was mentioned about the residents, including R#160. The only information provided about R#160 was that they were a new admit to the facility. RN E stated that they did a narcotic count with LPN D and they believed LPN D was going to leave the facility. RN E stated that they were about to start passing medication to the residents and CNA F indicated that they needed help with a resident which took about ,[DATE] minutes. RN E then returned to the medication cart to obtain R#160's medication and was going to check R#160's blood pressure when CNA F ran out of R#160's room and told them that R#160 was dead. RN E further reported that they entered into R#160's room and the resident's eyes and mouth were open and they used a stethoscope and noted that the resident did not have a pulse. RN E indicated that they logged into the computer and determined that the resident was a Full Code and went to obtain the crash cart and set up AED (automated external defibrillator) pads and CNA F helped them by putting up the backboard and a nurse from the 4th floor came to assist until EMS came and continued with CPR. Interviews with CNA C and CNA F did not indicate CPR was started after determining a resident #160 was unresponsive. During a phone interview, on [DATE] at approximately 10:40 AM, CNA N indicated that they were CPR certified, but in the event they observed a resident unresponsive, it would be a Nurse that would initiate CPR. On [DATE] at 11:26 AM, an interview was conducted and the DON was queried about initiating CPR. The DON explained all nurses and CNA's are CPR certified and can, and are expected to, initiate CPR. The DON was asked what CNA C should have done when she found R#160 unresponsive. The DON explained CNA C should have initiated CPR, and called for help to get the attention of other staff members. The DON further explained that the facility was small and a call for help can be heard by other staff members. The DON was asked if there were limitations on performing CPR on full code residents. The DON explained it did not matter how long a person had been unresponsive, when found, CPR was to be initiated. On [DATE] at 11:41 AM, an interview was conducted and the Medical Director was asked if he was aware of CPR not being initiated on a full code Resident. The Medical Director explained he was aware and had directed the facility to educate all nurses and CNA's on CPR. On [DATE] at approximately 12:14 PM, an observation of timed video obtained from the Facility's security system for dates [DATE] (start time -7:00 PM) through [DATE] (end time - approximately 8:00 AM) was conducted with the DON and AIT. The video did not contain audio. The video provided a clear observation of staff entering and exiting residents rooms on their assigned unit/hall. There was no evidence observed on the video that LPN D entered R#160's room to provide CPR, medication, monitoring, assessment, treatment and/or care to R#160 from 7:00 PM through 7:00 AM (12 hours). At approximately 7:14 AM on [DATE] the video indicated that CNA C entered into R#160's room and exited shortly thereafter and approached LPN D. At approximately 7:16 AM, both LPN D and CNA C enter into R#160's room and exited approximately one minute later at 7:17 AM. At 7:45 AM both LPN D and CNA C were observed exiting the unit. It should be noted that LPN D had initialed in a progress note dated [DATE] (7:02 AM), as noted above, that they had monitored the resident during the evening and the resident appeared alert and oriented. R#160 Medication Administration Record [REDACTED]. There was not evidence on the video that LPN D had entered into the resident's room or that the resident was provided medication/treatment at those times . Continued review of the Facility's security video showed CNA F entering into R#160's room at approximately 8:06 AM and exiting shortly thereafter and appears to call to RN E. Continued observation of the video reveals RN E was on the phone near the nurses station. At approximately 8:14 AM, both CNAF and RN E are observed entering into R#160's room with the crash cart. *It should be noted that the crash cart was brought into the residents room eight minutes after CNA F informed RN E that the resident appeared deceased . On [DATE] at 2:54 PM, an interview was conducted and LPN G was asked about R#160. LPN G explained she had admitted R#160 in the afternoon of Saturday, [DATE]. LPN G went on to explain that R#160 was completely alert and orientated and they had talked for a long time about R#160's life. LPN G was asked what she would have done if she had found R#160 unresponsive. LPN G explained that since R#160 had been a full code, she would have initiated CPR. LPN G further explained that she and LPN D had worked at the facility for several years and stated, I don't know how, not even as a nurse, but as a human being, how anyone could do that (not initiate CPR) to another person. LPN G was asked about CNA C. LPN G explained she didn't understand why CNA C didn't tell anyone else about finding R#160 unresponsive, as there was another nurse and CNA there at the time. LPN G stated, If it had been (Name Redacted, another CNA), she would have rolled right over (LPN D) and called the code herself. LPN G further explained after not doing anything for R#160, LPN D and CNA C gave report that R#160 was fine, punched out and left. LPN G stated, You wouldn't even do that to a dog. The Facility's Policy titled Emergency Procedure-Cardiopulmonary Resuscitation (Approval Date [DATE]) documented, in part, the following: Policy Statement: Personnel have completed training on the initiation of CPR and basic life support (BLS), including defibrillation, for victims of sudden [MEDICAL CONDITION] .General Guidelines: 1. Sudden [MEDICAL CONDITION] (SCA) is a loss of heart function due to abnormal heart rhythms. [MEDICAL CONDITION] occurs soon after symptoms occur. It is the leading cause of death among adults .4. a chance of surviving SCA may be increased if CPR is initiated immediately upon collapse .6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. it is know that a Do Not Resuscitate (DNR) order that specifically prohibits CPR .for that individual .8. if the first responder is not CPR certified that person will

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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	(continued... from page 3) call 911 .Emergency Procedure .1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing .begin CPR: . The Facility provided a plan to remove the immediacy and it was verified onsite by the survey team. The plan read in part: .The night shift LPN and C.N.A. identified in the incident were suspended on [DATE] pending investigation. Both staff members were terminated based on the outcome of the investigation on C.N.A. on [DATE] and LPN on [DATE] due to inability to contact before this date .Education for the LPN and C.N.A. identified was verified for CPR certification . Upon notification of the incident, education for all nursing staff was initiated immediately for the nursing staff. No staff member will work until education is completed. The education included: Emergency CPR - Education initiated for nursing staff relating to their respective roles and responsibilities relating to initiating CPR .Admission Policy to include Purple bracelets to identify DNR .Patient Death review of policy and procedure Upon notification of an immediate jeopardy, all nursing staff were re-educated by Nurse Management on the policy for Emergency CPR on [DATE] and [DATE]. Staff unavailable will not work until in services are complete .
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interviews, and record reviews, the facility failed to: (1) clean food service equipment, (2) maintain food service equipment, and (3) date mark all potentially hazardous ready-to-eat food products effecting 8 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and foodborne illness. Findings include: On 09/08/20 at 09:15 A.M., An initial tour of the food service was conducted with Dietary Cook W and Dietary Aide X. The following items were noted: One 5-pound container of Prairie Farms Low Fat Cottage Cheese approximately one-half full was observed without an open or use by date, within the #1 one-door reach-in cooler. The manufacturer best buy date that read 9/15/20 was observed stamped on the plastic container lid edge. Dietary Aide X stated: We place the open date on the container and use the best-buy date stamped on the container for the out date. The 2013 FDA Model Food Code section 3-501.17 states: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO -EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5C (41F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Dietary Manager (Registered Dietician) V indicated she would in-service the entire dietary staff on date marking procedures as soon as possible. The Convection Oven interior light was observed non-functional. Dietary Cook W indicated he would contact maintenance for necessary repairs. The 2013 FDA Model Food Code section 6-303.11 states: The light intensity shall be: (B) At least 215 lux (20-foot candles): (2) Inside EQUIPMENT such as reach-in and under-counter refrigerators. The convection oven door handle top insert was observed missing, allowing the set screw to dangle freely. The door handle was also observed extremely loose. Dietary Cook W indicated he would contact maintenance for necessary repairs as soon as possible. The Mechanical Dish Machine interior spray arm mount was observed with (loose, checked, frayed, and peeling) sealant material protruding around the perimeter of the mount plate. Dietary Cook W indicated he would have maintenance make necessary repairs as soon as possible. The 2013 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. The interior surface of the convection oven was observed soiled with dirt, grease, and accumulated/encrusted food residue. Dietary Cook W indicated the convection oven interior was cleaned routinely. Dietary Cook W also indicated he would thoroughly clean and sanitize the interior oven surfaces as soon as possible. The Coffee and Juice Machines were observed soiled with accumulated/encrusted food residue. Dietary Cook W indicated the Coffee and Juice Machines are cleaned every day. Dietary Cook W also indicated he would thoroughly clean and sanitize the beverage machines as soon as possible. The Ice machine interior door surface and plastic ice bin baffle assembly were observed with a black watery substance. Dietary Cook W indicated the ice machine is cleaned routinely. Dietary Cook W also indicated he would clean and sanitize the ice machine storage bin and door surface as soon as possible. The Stove ventilation hood filter was observed soiled with accumulated dust, dirt, and grease. Dietary Cook W indicated the ventilation hood system and filter are cleaned by an outside contractual company monthly. The four ceiling supply air grills and adjacent acoustical ceiling tiles were observed soiled with dust and dirt accumulations. Dietary Cook W indicated he would contact maintenance for necessary cleaning and repairs as soon as possible. The 2013 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 09/09/20 at 12:45 P.M., Record review of the Policy/Procedure entitled: Preventative Maintenance revealed under Policy: Department Managers participate in and administer a preventative maintenance program in the facility. Record review of the Policy/Procedure entitled: Preventative Maintenance further revealed under Procedure (3.): Responsibility for maintenance will vary depending upon contractual arrangements. If preventative maintenance is the responsibility of the Hospital, the Food Service Director obtains a copy of the maintenance schedule from the Hospital and inserts within the logbook. On 09/09/20 at 01:05 P.M., Record review of the Policy/Procedure entitled: Labeling/Dating revealed under Policy: All foods prepared in operation must be covered and labeled as to contents, date of preparation, use by date and employee name/initials prior to storage in refrigerators, freezers, and dry storage. Record review of the Policy/Procedure entitled: Labeling/Dating further revealed under Procedure (5.): Opened commercially prepared food items (ex. Cottage Cheese, Sour Cream, pre-cooked entrees must be labeled with Item Name, Prep Date, Use-By-Date, and Employee Name.
F 0947 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that eight Certified Nurse Aides (CNA) (identified as CNA F, I, K, M, N, P, Q, and R) out of eight CNA's whose in-service training files were reviewed, received 12 hours of annual training including, but not limited to, dementia and abuse training within the required time period, resulting in the potential for residents assigned to the CNAs who have a [DIAGNOSES REDACTED]. Findings include: On 9/10/20 at approximately 1:30 PM, an interview and record review of CNA files was conducted with Human Resource Staff (HR) U. No documentation was noted in the following CNA files: CNA F, date of hire (DOH) 8/12/19 CNA I, DOH 6/10/14 CNA K, DOH 12/14/17 CNA L, DOH 3/23/17 CNA M, DOH 10/28/08 CNA N, DOH 12/10/07 CNA P, DOH 3/10/10 CNA Q, DOH 10/19/15 HR U reported that the facility follows a yearly review for all CNAs in March/April of each year and indicated that there had been a change in staffing and was not sure that training and competency had been completed and suggested that the Director of Nursing (DON) may have the documents. On 9/10/20 at approximately 2:30 PM, the DON was asked to provide documentation that the current CNAs had received 12 hours of annual training. The DON indicated that they were recently hired and was not certain as to how to locate the documentation. A request for the facility's policy on CNA Training hours was requested. No policy or further documentation as to training was received by the end of the Survey.