STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015060	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TERRACE OAKS CARE & REHABILITATION CENTER	4201 BESSEMER SUPER HIGHWAY BESSEMER, AL 35020

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of Resident Identifier (RI) #1's medical record, the facility's admission packet, the facility's investigative file and the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, the facility failed to ensure Employee Identifier (EI) #1, a Licensed Practical Nurse (LPN), promptly provided Cardiopulmonary Resuscitation (CPR), to RI #1, a resident with Full Code status. Code status describes what type of intervention a health care facility will conduct should a resident stop breathing and/or heart stops beating. Full Code status means when a resident stops breathing and/or heart stops beating, staff are to immediately initiate emergency medical services, Cardiopulmonary Resuscitation (CPR), in an attempt to revive the resident. On [DATE] at 1:50 AM, EI #3, a Certified Nursing Assistant (CNA) noticed RI #1 was breathing funny and alerted the nurse, EI #1. EI #1 went into RI #1's room, cleaned the resident's mouth of a white foamy substance and noted RI #1 had shallow breathing. EI #1 left the resident's room to obtain an oxygen saturation monitor located at the nurses' station approximately 56 feet from RI #1's room. When EI #1 returned to the resident's room, EI #3, the CNA told EI #1 that she thought RI #1 was gone (no longer alive). EI #1 went back into RI #1's room to assess the resident's vital signs. After EI #1 could not obtain a pulse or respirations on RI #1, she instructed the CNA staff (EI #3 and EI #4) to change RI #1's incontinence brief (diaper). Instead of initiating CPR and directing the CNA staff to activate the emergency response system, EI #1 left the resident's room to call 911. After the CNA staff completed incontinence care, which took approximately five to 10 minutes, on RI #1, who had no pulse, CPR was initiated. When emergency medical services (EMS) arrived on the scene, they found RI #1 unresponsive, pupils fixed and dilated, without breath, or a pulse. RI #1 was pronounced dead at 2:14 AM on [DATE]. This deficient practice affected RI #1; one of four sampled residents reviewed for emergency response, and placed RI #1 in immediate jeopardy because it was likely to cause serious injury, harm or death. On [DATE] at 9:45 AM, the facility's Administrator, Director of Nursing, Staff Development Coordinator, and Vice President of Clinical Services were notified of the finding of substandard quality of care at the immediate jeopardy level of J in the area of Quality of Care, F 309. The immediate jeopardy began [DATE] and was relieved onsite on [DATE]. Findings include: The 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care with a copyright date of 2010 documented . Part 4: CPR Overview . The Universal Adult Basic Life Support (BLS) Algorithm is a conceptual framework for all levels of rescuers in all settings. It emphasizes the key components that any rescuer can and should perform. When encountering a victim of sudden adult [MEDICAL CONDITION], the lone rescuer must first recognize that the victim has experienced a [MEDICAL CONDITION], based on unresponsiveness and lack of normal breathing. After recognition, the rescuer should immediately activate the emergency response system, get an AED/defibrillator, if available, and start CPR with chest compressions. If an AED is not close by, the rescuer should proceed directly to CPR. If other rescuers are present, the first rescuer should direct them to activate the emergency response system and get the AED/defibrillator; the first rescuer should start CPR immediately . If an AED/defibrillator is not available, continue CPR without interruptions until more experienced rescuers assume care . rescuers should start CPR immediately if the adult victim is unresponsive and not breathing or not breathing normally . CPR improves the victim's chance of survival by providing heart and brain circulation. Rescuers should perform chest compressions for all victims in [MEDICAL CONDITION], regardless of rescuer skill level, victim characteristics, or available resources . RI #1 was admitted to the facility on [DATE] from a local hospital with a primary admit [DIAGNOSES REDACTED]. RI #1's ADM--Admission Nursing Assessment dated [DATE] indicated RI #1 was a Full Code. RI #1's history and physical examination [REDACTED]. Within the facility's admission packet was a document titled TERRACE OAKS CARE AND REHABILITATION CENTER ADVANCED DIRECTIVES which indicated all measures of resuscitation will be taken including: CPR, calling 911 and emergency IVs or medication when a resident has Full Code status. RI #1's undated care plan titled Advanced care planning . had a goal of Resident/Healthcare Decision Maker current wishes will be honored regarding advanced directives On [DATE], the State Agency received a complaint alleging the charge nurse responsible for RI #1 delayed initiating CPR on two occasions: 1) The charge nurse waited outside RI #1's room for the staff to bring the crash cart before proceeding into the room to initiate CPR; and 2) Once in the room, the charge nurse directed the CNA staff to change the resident's incontinence brief (diaper) before initiating CPR. A telephone interview was conducted on [DATE] at 3:40 PM, with EI #3, the 11:00 PM - 7:00 AM CNA assigned to care for RI #1 on [DATE]. EI #3 stated during her 12:00 AM rounds (on [DATE]), RI #1 was fine. Then a little before 2:00 AM, EI #3 noticed RI #1 was breathing funny, so she went to find the nurse, EI #1. According to EI #3, EI #1 came immediately to RI #1's room, then left to go and get an oxygen (O2) saturation (sat) monitor. EI #3 stated once EI #1 came back to RI #1's room, she could not get the O2 monitor to read. EI #3 stated once RI #1 was cleaned up (incontinence care provided), EI #1 started chest compressions on RI #1. A telephone interview was conducted on [DATE] at 2:20 PM, with EI #1, the 11:00 PM - 7:00 AM LPN assigned to care for RI #1 on [DATE]. According to EI #1, the CNA (EI #3) noticed foam coming out of RI #1's mouth around 1:50 AM and she (CNA) came and got her (LPN) to look at the resident. EI #1 stated she went to RI #1's room, cleaned the resident's mouth and noticed RI #1 had shallow breathing. EI #1 left the resident's room to get her oxygen saturation monitor from the medication cart, located at the nurses' station. After returning to RI #1's room, the CNA (EI #3) told her she thought RI #1 was gone. EI #1 went into RI #1's room in an attempt to get RI #1's vital signs, but the O2 monitor would not register. EI #1 then left RI #1's room and went to the nurses' station to call the other nurse on duty (EI #2) and 911. Once the other nurse (EI #2) made it to the nurses' station and while on the phone with 911, EI #1 asked EI #2 to go and get the crash cart. After calling 911, EI #1 instructed another CNA (EI #4) to assist EI #3 in changing RI #1's incontinence brief. After incontinence care was provided, EI #1 stated she began chest compressions, EI #4 did the Ambu bag and EI #3 just watched. EI #1 explained that EI #2, the other LPN, left RI #1's room after she bought the crash cart, and she saw the CNA staff had to finish providing incontinence care. According to EI #1, while EI #2 waited on the CNA staff to finish, another resident began to holler out for help, so EI #2 left RI #1's room to tend to the resident who was hollering out for help. RI #1's Departmental Notes written by EI #1, dated [DATE] 6:30 AM, documented . 1:50 AM Called to room per CNA and noted resident foaming @ (at) the mouth and having shadow (shallow) breathing. Went to desk to get O2 sat monitor and CNA called me back to room. Could not get O2 Sat on resident nor vital signs. 1:55 AM Call 911 and code in facility went back to resident room and preceded (proceeded) CPR until first responders arrived. First responders and police arrived @ 2:07 AM. They took over and pronounced . expired @ 2:14 AM . Within the facility's investigative file was a handwritten document signed by EI #1, the 11:00 PM - 7:-00 AM LPN assigned to

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) care for RI #1 on [DATE], which read [DATE] At 1:50 AM a code was called . In a follow-up interview on [DATE] at 1:00 PM, EI #1 stated, at 1:50 AM the CNA (EI #3) came and got her; that's when white foam was observed in the resident's mouth. EI #1 stated she could not get a pulse and she couldn't recall if she tried to get a carotid (neck) pulse or radial (wrist) pulse. When asked, if she checked RI #1's vital signs before or after she instructed the CNAs to change RI #1's incontinence brief, EI #1 stated she already had checked RI #1's vital signs, when she asked EI #4 to assist EI #3 in changing RI #1's incontinence brief. EI #1 stated as she was talking to the CNAs about changing RI #1's incontinence brief, she left RI #1's room to call 911. On [DATE] at 4:05 PM, EI #9, the Maintenance Director, was asked to measure the distance from station two nurses' station to RI #1's room. EI #9 stated it was 56 feet from the nurses' station to RI #1's room. Within the facility's investigation file was a handwritten note from EI #4, a CNA, which documented [DATE] Incident Report At about 1:50, AM, I was changing Resident in Room # ., I was called by (EI #1) to assist in (RI #1's room) . we were asked to change the resident diaper . During a telephone interview on [DATE] at 1:25 PM, EI #4, a CNA, stated EI #1 (LPN) asked him to change RI #1's incontinence brief (diaper). According to EI #4, CPR was not started until after he and EI #3 changed RI #1's incontinence brief. In a follow-up interview on [DATE] at 2:15 PM, EI #4 was asked if he thought RI #1 was deceased when the resident's incontinence brief was changed. EI #4 stated yes, but he was not authorized to confirm it. When asked, how long it took to change RI #1's incontinence brief, EI #4 stated RI #1 was a large person, so about ,[DATE] minutes. During a telephone interview on [DATE] at 4:00 PM, EI #2, (the LPN who brought the crash cart to RI #1's room) was asked to recall the events that occurred on [DATE]. According to EI #2, she was on Station I when she heard EI #1 call her name on the intercom system. EI #2 stated she immediately went to Station II, where she observed EI #1 and EI #3 standing at the nurses' station. EI #2 stated EI #1 was not on the phone; EI #1 asked EI #2 to bring the crash cart. EI #2 stated after she was told the crash cart was needed, she ran back to Station I to get the crash cart. When EI #2 returned to Station II, she saw EI #1 and EI #3 still standing in the hallway. EI #2 then explained how all three (EI #1, EI #2 and EI #3) went to RI #1's room. EI #2 stated when she went into RI #1's room, she observed that the resident was not breathing. According to EI #2, as she began to pull the plastic off the Ambu bag (a hand-held device commonly used to provide ventilation to patients who are not breathing or not breathing adequately), EI #1 told the CNA staff to change RI #1's diaper (incontinence brief). EI #2 explained that she was trying to get ready to start CPR but EI #1 instructed the CNA staff to change RI #1's incontinence brief. EI #2 stated as she backed away from RI #1's bed with the crash cart, she heard another resident yell out in help, so she left the room to assist the other resident. EI #2 stated she never returned to RI #1's room because as she was assisting the other resident and she observed EMS coming down the hall. In a follow-up interview on [DATE] at 8:20 AM, EI #2 was asked, why she didn't start CPR. EI #2 replied that when she walked in RI #1's room, her intention was to start CPR; however, EI #1, the nurse assigned to care for RI #1, was adamant that the CNA staff change RI #1's incontinence brief. EI #2 further stated that EI #1 delayed initiation of CPR. During an interview on [DATE] at 4:15 PM, EI #6, the Assistant Director of Nursing (ADON), acknowledged RI #1 had Full Code status. When asked, when CPR should be initiated, EI #6 stated, as soon as you find a resident unresponsive, no pulse and not breathing. The local EMS report indicated 911 was notified on [DATE] at 1:55 AM, with a dispatch complaint of [MEDICAL CONDITION] for RI #1. At 2:01 AM, EMS arrived on the scene and found RI #1 unresponsive, apneic (absence of breathing), pulseless, pupils fixed and dilated, with asystole (absence of heartbeat) on all three leads. According to RI #1's ALABAMA Certificate of Death, RI #1's time of death was [DATE] 2:14 AM. ********** On [DATE] at 4:00 PM, the facility submitted an acceptable Allegation of Credible Compliance, which documented F 309-Quality of Care Two licensed nurses were terminated on [DATE] for allegedly failing to provide timely CPR. The two licensed nurses who were terminated will be reported to the ABN (Alabama Board of Nursing) by [DATE]. Licensed staff were in-serviced and took a post-test on revised policy entitled Cardio [MEDICAL CONDITION] Resuscitation on [DATE] and [DATE] by an RN/Staff Development Coordinator. The in-service included a review of the revised policy and procedure, what to do if someone is found not breathing, how to call a code, and to perform CPR until EMS arrives and takes over . ********** After reviewing the facility's information provided in their Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 309 was lowered to a D level on [DATE] at 4:30 PM, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL 151.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, Employee Identifier (EI) #8, the Administrator, who was responsible for directing the overall operation of the facility and EI #7, the Director of Nursing, who was responsible for the overall operation of the nursing service department, failed to ensure a system was in place for all staff to readily identify a resident's code status. The resident's code status was documented on the physician's orders [REDACTED]. Furthermore, EI #7 and EI #8 failed to ensure licensed nurses maintained current Cardiopulmonary Resuscitation (CPR) certification. These deficient practices affected RI #1, one of four sampled residents reviewed for emergency response, with the potential to affect the remaining 48 Full Code status residents who reside in the facility. These deficient practices placed RI #1 in immediate jeopardy because it was likely to cause serious injury, harm or death. The facility's RESIDENT CENSUS AND CONDITIONS OF RESIDENTS (Form CMS-672) dated [DATE], indicated the facility had a total of 62 residents. On [DATE] at 9:45 AM, the facility's Administrator, Director of Nursing, Staff Development Coordinator, and Vice President of Clinical Services were notified of the finding of substandard quality of care at the immediate jeopardy level of K in the area of Administration, F 490. The immediate jeopardy began [DATE] and was relieved onsite on [DATE]. Findings include: Cross reference F 309 and F 493. The Director of Nursing, EI #7's, job description revised [DATE], documented . Basic Job Responsibility . To assure that the Nursing Service Department is in compliance with rules and regulations of Federal, State and local authorities. The primary purpose of the position is to plan, organize, develop and direct the overall operation of the Nursing Service Department to ensure the highest degree of quality care is maintained at all times. As the Director of Nursing, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties . The Administrator, EI #8's, undated job description documented . BASIC FUNCTION Responsible for directing the overall operation of the facility's activities in accordance with current applicable federal, state and local standards, guidelines and regulations and as directed by the governing board and for ensuring that the highest degree of quality patient/resident care is maintained at all times . ESSENTIAL FUNCTIONS 1. Establish and direct the implementation of written policies and procedures that reflect the goals and objectives of the facility . 2. Assist in the development and implementation of departmental policies and procedures . 1) On [DATE] at 3:00 PM, a tour of the facility was completed. The facility had no system in place to readily access a resident's code status. In a telephone interview on [DATE] at 1:25 PM, EI #4, a CNA was asked, how he knew the code status of a resident. EI #4 replied, the charge nurse. In a telephone interview on [DATE] at 2:20 PM, EI #1, an LPN was asked, how she knew the code status of a resident. EI #1 replied, the resident's medical record. In a telephone interview on [DATE] at 3:40 PM, EI #3, a CNA was asked, how she knew the code status of a resident. EI #3 replied that she didn't. In a telephone interview on [DATE] at 4:00 PM, EI #2, an LPN was asked, how she knew the code status of a resident. EI #2 replied it was in the front of the resident's medical record. In an interview on [DATE] at 4:15 PM, EI #6, the Assistant Director of Nursing (ADON), was asked, where the residents' code status was documented. EI #6 stated, in the residents' medical record.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) During an interview on [DATE] at 8:20 AM, EI #7, the Director of Nursing (DON), was asked, where was the code status of a resident documented. EI #7 stated, in the resident's medical record and Medication Administration Record [REDACTED]. In a follow-up interview on [DATE] at 2:00 PM, EI #7 was asked if the staff found a resident without a pulse or respiration, how would they know to start CPR without going and looking at the resident's medical record, located at the nurses' station. EI #7 stated, in the front of the Medication Administration Record [REDACTED]. 2) According to a typed list dated [DATE], the facility employs 18 licensed nurses. After a review of CPR certification records, it was determined EI #2, the LPN who brought the crash cart into RI #1's room on [DATE], was not CPR certified. EI #2's certification expired [DATE]. EI #10, another licensed nurse's CPR certification expired February 2015 and EI #11, an LPN, was not certified by an approved CPR course. In an interview on [DATE] at 8:05 AM, EI #12, the Staff Development Coordinator, was asked who monitored to ensure the licensed nursing staff maintained current CPR certification. EI #12 stated, the Director of Nursing, EI #7. In an interview on [DATE] at 8:20 AM, EI #7, the DON, stated he was unaware that EI #2's CPR certification had expired when she responded to RI #1 being found without pulse or respirations on [DATE]. In an interview on [DATE] at 3:30 PM, EI #8, the Administrator, was asked who was responsible for monitoring CPR certification for licensed nurses. EI #8 stated that EI #7, the DON was but EI #12, the Staff Development Coordinator was taking over this responsibility. ********** On [DATE] at 4:00 PM, the facility submitted an acceptable Allegation of Credible Compliance, which documented F 490-Administration The facility immediately implemented a color code system on [DATE] on care cards located in each resident room to readily identify code status of residents. The color code system is called the CPR identification Protocol and was competed on [DATE] with each resident's care card being marked with an orange DNR sticker or a green Full Code sticker. The facility currently identifies code status in two ways as follows: under Physicians Order tab in resident's chart and a current list of DNR residents is kept in the front of the MAR indicated [REDACTED]. No one without proof of current CPR certification has worked since [DATE]. Any licensed nursing staff without proof of current CPR certification will be removed from the nursing schedule and will not work until proof of current CPR certification is received. One licensed nurse remains that has not provided proof of current CPR certification, and she has been removed from the schedule until it is obtained. Licensed and non-licensed staff will be in-serviced by Social Worker or RN/Staff Coordinator or Designee on the new CPR Identification Protocol on [DATE] through [DATE]. Staff development coordinator was in-serviced on [DATE] by Administrator to obtain CPR certification cards upon hire and to maintain current CPR certifications for licensed staff. ********** After reviewing the facility's information provided in their Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 490 was lowered to a E level on [DATE] at 4:30 PM, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL 151.
F 0493 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**1) Set up a group that is legally responsible for writing and setting up policies for leading and running the nursing home; or 2) hire a properly licensed administrator.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, Employee Identifier (EI) #13, the Vice President of Clinical Services (VPCS), who is responsible to provide and/or coordinate services that will assist the facility to promote programs in accordance with current federal, state, and local guidelines, regulations and standards, failed to ensure the facility had a policy/procedure in place which directed the staff how to respond when they found a resident without a pulse or respirations. During the third shift (11:00 PM - 7:00 AM) on [DATE], Employee Identifier (EI) #1, a Licensed Practical Nurse determined that Resident Identifier (RI) #1, did not have a pulse or respiration. Instead of immediately initiating CPR and directing the staff present in the resident's room to activate the emergency response system, EI #1 instructed the staff to perform incontinence care on RI #1, then left the resident's room to call 911. EI #13 further failed to ensure the facility's Cardiopulmonary Resuscitation (CPR) policy was updated with the 2010 American Heart Association (AHA) Standards for CPR, and in keeping with the Alabama Board of Nursing (ABN) standards. The facility's policy allowed licensed staff to use their judgment in determining whether or not to initiate CPR on a resident with Full Code Status. These deficient practices affected RI #1, one of four sampled residents reviewed for emergency response, with the potential to affect the remaining 48 Full Code status residents who reside in the facility. These deficient practices placed RI #1 in immediate jeopardy because it was likely to cause serious injury, harm or death. The facility's RESIDENT CENSUS AND CONDITIONS OF RESIDENTS (Form CMS-672) dated [DATE], indicated the facility had a total of 62 residents. On [DATE] at 9:45 AM, the facility's Administrator, Director of Nursing, Staff Development Coordinator, and Vice President of Clinical Services were notified of the finding of substandard quality of care at the immediate jeopardy level of K in the area of Governing Body, F 493. The immediate jeopardy began [DATE] and was relieved onsite on [DATE]. Findings include: Cross reference F 309 and F 490. EI #13, the Vice President of Clinical Services' job description revised [DATE], documented . Summary of Responsibilities To provide and/or coordinate services that will assist facilities to promote, to the highest degree, programs in accordance with current applicable federal, state, and local guidelines, regulations and standards to provide quality resident care at all times . 5. Assists facility management with development of appropriate resident care policies and procedures. 6. Conducts facility reviews to assess compliance with Federal and State regulations . 12. Remains current on State and Federal regulations, assisting with interpretation as needed . The facility's policy titled, Cardio [MEDICAL CONDITION] Resuscitation (CPR) NP.VII-4 with an effective date of [DATE], documented . STANDARD: . The licensed nurse makes his/her best judgement (judgment), based upon the time passing and the clinical symptoms of the resident, whether to initiate CPR on a resident . PROCESS: 1. Begin compressions and assisted ventilation within four minutes immediately after the following symptoms occur: *No pulse *No respirations *No heartbeat *Unconsciousness . The 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care with a copyright date of 2010 documented . Part 4: CPR Overview . The Universal Adult Basic Life Support (BLS) Algorithm is a conceptual framework for all levels of rescuers in all settings. It emphasizes the key components that any rescuer can and should perform. When encountering a victim of sudden adult [MEDICAL CONDITION], the lone rescuer must first recognize that the victim has experienced a [MEDICAL CONDITION], based on unresponsiveness and lack of normal breathing. After recognition, the rescuer should immediately activate the emergency response system, get an AED/defibrillator, if available, and start CPR with chest compressions. If an AED is not close by, the rescuer should proceed directly to CPR. If other rescuers are present, the first rescuer should direct them to activate the emergency response system and get the AED/defibrillator; the first rescuer should start CPR immediately . If an AED/defibrillator is not available, continue CPR without interruptions until more experienced rescuers assume care . rescuers should start CPR immediately if the adult victim is unresponsive and not breathing or not breathing normally . CPR improves the victim's chance of survival by providing heart and brain circulation. Rescuers should perform chest compressions for all victims in [MEDICAL CONDITION], regardless of rescuer skill level, victim characteristics, or available resources . According to the Alabama Board of Nursing, Alabama Administrative Code Chapter 610-X-6 Standards of Nursing Practice . 610-X-6-.03 Conduct and Accountability. The registered nurse and licensed practical nurse shall: (1) Have knowledge and understanding of the laws and rules regulating nursing. (2) Function within the legal scope of nursing practice . (7) Accept individual responsibility and accountability for judgments, actions and nursing competency, remaining current with technology and [MEDICATION NAME] consistent with facility policies and procedures . 610-X-6-.04 Practice of Professional Nursing (Registered Nurse Practice (1) The practice of professional nursing includes, but is not limited to: . (b) Provision of care supportive to or restorative of life and well-being .

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F 0493 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) The Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards and Quality/Survey & Certification Group memorandum issued [DATE] and revised [DATE], with a subject of Cardiopulmonary Resuscitation (CPR) in Nursing Homes, documented . Initiation of CPR - Prior to the arrival of emergency medical services (EMS), nursing home must provide basic life support, including initiation of CPR, to a resident who experiences [MEDICAL CONDITION] (cessation of respirations and/or pulse) in accordance with that resident's advance directives or in the absence of advance directives or a Do Not Resuscitate (DNR) order . A. Background . The American Heart Association (AHA) publishes guidelines every five years for CPR and Emergency Cardiovascular Care (ECC). According to the AHA, reversal of clinical death is among the goals of ECC since brain damage begins four to six minutes following [MEDICAL CONDITION] if CPR is not administered during that time . AHA guidelines for CPR provide the standard for the American Red Cross, state EMS agencies, health providers, and the general public . D. Survey Implications When reviewing facility policies and procedures related to emergency response, surveyors should ascertain that facility policy, at a minimum, directs staff to initiate CPR as appropriate. Facility policy should specifically direct staff to initiate CPR when [MEDICAL CONDITION] occurs for residents who have requested CPR in their advance directives, who have not formulated an advance directive, who do not have a valid DNR order, or who do not show AHA signs of clinical death as defined in the AHA Guidelines for CPR and Emergency Cardiovascular Care (ECC) . On [DATE] at 1:50 AM, EI #3, a Certified Nursing Assistant (CNA) noticed that RI #1 was breathing funny and alerted the nurse, EI #1. EI #1 went into RI #1's room, cleaned the resident's mouth of a white foamy substance and noted RI #1 had shallow breathing. EI #1 left the resident's room to obtain an oxygen saturation monitor located at the nurses' station approximately 56 feet from RI #1's room. When EI #1 returned to the resident's room, EI #3, the CNA told EI #1 that she thought RI #1 was gone (no longer alive). EI #1 went back into RI #1's room to assess the resident's vital signs. After EI #1 could not obtain a pulse or respirations on RI #1, she instructed the CNA staff (EI #3 and EI #4) to change RI #1's incontinence brief (diaper). Instead of initiating CPR and directing the CNA staff to activate the emergency response system, EI #1 left the resident's room to call 911. After the CNA staff completed incontinence care, which took approximately five to 10 minutes, on RI #1, who had no pulse, CPR was initiated. When emergency medical services (EMS) arrived on the scene, they found RI #1 unresponsive, pupils fixed and dilated, without breath, or a pulse. RI #1 was pronounced dead at 2:14 AM on [DATE]. In an interview on [DATE] at 4:15 PM, EI #6, the Assistant Director of Nursing (ADON), was asked, what was the facility's policy for calling codes? EI #6 explained since the facility was small, they just overhead paged that a nurse was needed to a room stat (immediately) or sometimes the staff would just run and get a nurse. In an interview on [DATE] at 8:20 AM, EI #7, the Director of Nursing (DON), was asked, what was the facility's policy on calling a code, EI #7 stated it depends and explained if the staff was in the hallway, they would just holler; if no staff were in the hallway, they would overhead page. During an interview on [DATE] at 9:35 AM, EI #8, the Administrator was asked if the facility's CPR policy was current with the American Heart Association (AHA) guidelines. EI #8 replied that she assumed it was and explained that EI #13, the Vice President of Clinical Services (VPCS), handled that. An interview was conducted with EI #13, the Vice President of Clinical Services on [DATE] at 11:25 AM. The surveyor asked EI #13 if the facility's CPR policy that indicated a nurse could make a judgment whether or not to initiate CPR was based on the AHA guidelines or the Alabama Board of Nursing. EI #13 replied, she didn't think so. EI #13 explained that if a nurse found a resident without vital signs, they should determine the resident's code status, initiate CPR and contact 911. When asked, what the facility's CPR was based on, EI #13 stated she couldn't answer that because she didn't develop the policy. EI #13 was asked, if the facility had a policy on how to respond when a resident was found without a pulse or respiration and she said no. ********** On [DATE] at 4:00 PM, the facility submitted an acceptable Allegation of Credible Compliance, which documented F493 Governing Body Policy entitled Cardio [MEDICAL CONDITION] Resuscitation was revised on [DATE] by the Vice President of Clinical Services to include staff directions on what to do if a resident stops breathing per AHA, ABN, and CMS guidelines. The Medical Director approved the policy entitled Cardio [MEDICAL CONDITION] Resuscitation on [DATE]. Licensed staff have been in-serviced on the revised policy entitled Cardio [MEDICAL CONDITION] Resuscitation by RN/Staff Development Coordinator or Designee on [DATE] through [DATE]. ********** After reviewing the facility's information provided in their Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 493 was lowered to an E level on [DATE] at 4:30 PM, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL 151.