STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **015458**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLENNIUM NURSING & REHAB CENTER, INC	**5275 MILLENNIUM DRIVE HUNTSVILLE, AL 35806**

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 0155

Level of harm - Immediate jeopardy

Residents Affected - Few

Let the resident refuse treatment or refuse to take part in an experiment and formulate advance directives.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interviews, review of Resident Identifier (RI) #1's medical record, a handwritten statement from a licensed nurse and the 2010 American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, Employee Identifier (EI) #1, a Licensed Practical Nurse (LPN) failed to honor the resident rights of Resident Identifier (RI) #1, a resident with Full Code status. On [DATE] between 3:00 AM and 4:00 AM, EI #1, the lone rescuer, could not detect RI #1's pulse. EI #1 lowered RI #1's bed and started to perform chest compressions. After 30 chest compressions, EI #1 checked for a pulse. When no pulse was found, EI #1, the lone rescuer, stopped CPR and returned to the nurses' station to complete paperwork. EI #1 did not call a code, activate emergency medical services (EMS) or receive orders from the physician, before she informed RI #1's daughter, the resident had passed away. According to the AHA, the lone rescuer should immediately activate the emergency response system, get an AED (Automated External Defibrillator)/defibrillator, if available, and start CPR with chest compressions. CPR should be continued without interruptions until more experienced rescuers assume care.
This deficient practice affected RI #1; one of two 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 6:15 PM, the facility's Administrator, Director of Nursing (DON), and two Regional Nurse Consultants were notified of the findings of immediate jeopardy in the area of Resident Rights, F 155.

Findings include:
Cross reference F 309.
According to page 25 of the facility's Director of Nursing Training Manual dated [DATE] titled ADVANCE DIRECTIVES,POLICY Adult patients are informed and written information provided regarding the right to accept or refuse medical or surgical treatment and, at the individual's option, formulates an advance directive .
On [DATE], the State Agency received a complaint alleging the facility failed to initiate and continue CPR on RI #1, a resident with Full Code status. The ambulance was not called and there was no crash cart in the resident's room or hallway. According to the complainant, the Director of Nursing (EI #2) stated the nurse (later identified as EI #1) got into trouble for not calling the ambulance.
RI #1 was admitted to the facility on [DATE].
RI #1's ADVANCE DIRECTIVE ACKNOWLEDGEMENT form signed by RI #1's daughter dated [DATE] indicated RI #1 had not executed an
Advance Directive; therefore, RI #1 was a Full Code.
In a telephone interview on [DATE] at 5:30 PM, RI #1's daughter stated she received a phone call on [DATE] at 4:17 AM from EI #1 (LPN), who stated RI #1 was barely breathing and that CPR had been attempted. RI #1's daughter stated she arrived at the facility at 4:50 AM. According to RI #1's daughter, the Director of Nursing (EI #2) told her the ambulance was not called and the nurse, EI #1, got into trouble for not calling the ambulance.
In a telephone interview on [DATE] at 10:40 AM, EI #1, a LPN, acknowledged that she provided care to RI #1 on [DATE]. When asked about the events that took place with RI #1 on [DATE], EI #1 stated EI #8,a Certified Nursing Assistant (CNA), told her to come and check RI #1's vital signs. EI #1 stated when she went to RI #1's room to check the resident's vital signs, the resident's pulse was very faint. EI #1 left RI #1's room to call EI #3, a Registered Nurse, the physician and RI #1's family. EI #1 stated she returned to RI #1's room and began CPR by doing chest compressions for as long as she could. EI #1 was asked, how long she performed CPR and she stated she was not sure. When asked if she called a code, EI #1 said No, I did not. When asked if she called an ambulance (activate EMS), EI #1 said no ma'am. EI #1 was asked, what the facility's policy directed her to do when she found a resident unresponsive. EI #1 replied, to call a code, call (activate) the emergency response system and continue CPR until EMS arrives. When asked if she followed the facility's policy, EI #1 said no. EI #1 revealed a couple of days later, after RI #1 expired in the facility, the DON (EI #2) re-educated her about calling a code and the ambulance. When asked, why she did not call 911, EI #1 stated she was trying to get RI #1 back and she didn't think to call 911. EI #1 further stated, In hindsight, I should have called 911.
In a follow-up interview on [DATE] at 8:10 AM, EI #1 stated when she entered RI #1's room, the resident had very shallow movements and a faint radial pulse. After noticing this, EI #1 left the resident's room to call the physician, RI #1's daughter and the Registered Nurse (RN), EI #3. EI #1 stated while she was talking with RI #1's daughter, she asked for verification purposes, what the resident's code status was. EI #1 stated RI #1 was not a DNR (Do Not Resuscitate); therefore, the resident was a Full Code. When asked if she spoke with the physician, EI #1 stated no, it went to a pager and she left the facility's number for the physician to call back. According to EI #1, she went back to RI #1's room and tried to arouse the resident but she could not feel a pulse or anything. At that point, EI #1 stated she lowered the resident's bed and started chest compressions. EI #1 stated she did 30 chest compressions, then checked for a pulse. When asked, if any staff member was in RI #1's room with her, EI #1 stated not that I can remember. EI #1 was asked, if the physician called her back. EI #1 replied, as she was on her way back to the nurses' station, someone (name unknown) said the physician was on the phone. When asked, what the physician said, EI #1 said the physician said stop CPR and release RI #1's body to the funeral home. EI #1 acknowledged she had already stopped CPR by the time the physician called back and gave the order to stop CPR. When asked, if a nurse can just stop CPR when she wants to, EI #1 said no. EI #1 was asked, approximately what time did this event occur, she answered somewhere between 3:00 AM - 4:00 AM.
EI #1's handwritten statement dated [DATE] documented On [DATE] I was told by the CNA that I needed to come check (RI #1) because (he/she) was unresponsive and said CNA could not get vital signs on (him/her). The time was 0400 (4:00 AM). I went in and tried to palpate a pulse (radial & carotid). I found a faint pulse and shallow rise and fall of the chest. I then called for assistance of a RN on duty at that time. I called the daughter and the doctor to inform them of the situation. I returned to the room and couldn't palpate a pulse and didn't see any movement of the chest or abdominal region. I called again to let the RN know what was happening and returned to (RI #1) and attempted CPR . (RI #1's) nail beds were purple in color and (his/her) hands were cool to touch. (The physician) called after 0500 (5:00 AM) and said stop CPR and gave order to release body to the funeral home .
RI #1's electronic nurses' note entered by EI #1 dated and timed [DATE] at 4:39 AM (timed 21 minutes before the physician called back to inform the staff to stop CPR) documented . 0400 (4:00 AM) unable to palpate vital signs, skin cool to touch finger tips purple. CPR attempted without success. (The physician) paged, order given to stop code and release body to funeral home of family's choice, daughter notified, stated they are on their way.

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 0155

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)
In a telephone interview on [DATE] at 2:45 PM, EI #3, a Registered Nurse (RN) acknowledged she was working in the facility on the morning RI #1 expired ([DATE]). According to EI #3, she and another RN (EI #4), were working on the 100 hall, when EI #4 answered the phone and was informed by EI #1 that RI #1 had expired. EI #3 stated about five minutes had passed when she went over to the 100 hall, where she saw EI #1 at the nurses' station. According to EI #3, EI #1 told her she had already done CPR. After finding out the resident's code status, EI #3 stated she went to RI #1's room, where she found the CNAs already performing post mortem care. EI #3 listened with a stethoscope for vital signs and there were none; the resident had expired. EI #3 stated she told EI #1 to call the doctor and the family, but EI #1 stated she had already done that. When asked, what the facility's process was for calling a code, EI #3 stated overhead page, code blue to the resident's room. EI #1 further stated That was not done that night. She (EI #1) just called us (EI #3 and EI #4) on the phone (and) said she needed help. When asked, how long should the code be performed, EI #3 stated until EMS comes, but they didn't come because no one called them.
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On [DATE] at 10:40 AM, the facility submitted an acceptable Allegation of Credible Compliance, which documented . F155 . Resident Identifier #1 . - The Medical Director/physician was notified on [DATE] by the DON that the facility failed to honor the advanced directive of cardiopulmonary resuscitation (CPR) status for two residents with full code status.
The EI #1 received in-service training on [DATE] and [DATE] by the Director of Nursing and Regional Nurse Consultant. The in-service covered areas but not limited to: Advance Directive, Code Status, CPR, (The facility will follow The American Heart Association), Code Blue, and activation of Emergency Medical Services
On [DATE] EI #1 was removed from the schedule indefinitely by the DON. On [DATE] EI #1 employment was terminated.
Members of the Interdisciplinary Team (Social Service, Staffing, Coordinator, Medical Records, Treatment Nurse and MDS Coordinators) audited all residents' medical records, conducted resident and responsible party interviews for residents' choice of Advance Directives to include cardiopulmonary resuscitation (CPR) on [DATE], and [DATE]. Orders were obtained from the resident's physician to reflect each choices regarding Advance Directives including code status.
All licensed nurses were in-serviced on [DATE] and on [DATE] to follow the American Heart Association CPR guidelines.
On [DATE] The CPR policy was added to all new hire orientation process.
AOC [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 155 was lowered to D level on [DATE] at 6:15 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 869.

F 0309

Level of harm - Immediate jeopardy

Residents Affected - Some

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 and RI #2's medical record, handwritten statements from licensed nurses and the 2010 American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, the facility failed to ensure Employee Identifier (EI) #1, a Licensed Practical Nurse (LPN) followed the AHA guidelines for providing cardiopulmonary resuscitation 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 their heart stops beating. Full Code status means when a resident stops breathing and/or their heart stops beating, staff are to immediately initiate emergency medical services, Cardiopulmonary Resuscitation (CPR), in an attempt to revive the resident. According to the AHA, the lone rescuer should immediately activate the emergency response system, get an AED (Automated External Defibrillator)/defibrillator, if available, and start CPR with chest compressions. CPR should be continued without interruptions until more experienced rescuers assume care. On [DATE] between 3:00 AM and 4:00 AM, EI #8, a Certified Nursing Assistant (CNA) alerted EI #1, the LPN that she should come and check on RI #1. EI #1 went into the resident's room and found RI #1 with a faint pulse. EI #1 left the resident's room to call the physician, the resident's family and EI #3, a Registered Nurse on another hall. When EI #1 returned to RI #1's room, she could not detect RI #1's pulse. EI #1 lowered RI #1's bed and started to perform chest compressions. After 30 chest compressions, EI #1 checked for a pulse. When no pulse was found, EI #1 stopped CPR and returned to the nurses' station to complete paperwork. Without calling a code, activating emergency medical services (EMS) or notification from the physician, EI #1 told RI #1's daughter, the resident had expired when she arrived at the facility at 4:50 AM.
Furthermore, it was revealed, this same LPN, EI #1, who was not CPR certified, failed to call a code and activate the emergency response system, when she found RI #2 unresponsive on [DATE].
These deficient practices affected RI #1 and RI #2; two of two sampled residents reviewed for emergency response, and placed RI #1 and RI #2 in immediate jeopardy because it was likely to cause serious injury, harm or death.
On [DATE] at 6:15 PM, the facility's Administrator, Director of Nursing (DON), and two Regional Nurse Consultants were notified of the findings of substandard quality of care at immediate jeopardy in the area of Quality of Care, F 309.
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 .
On [DATE], the State Agency received a complaint alleging the facility failed to initiate and continue CPR on RI #1, a resident with Full Code status. The ambulance was not called and there was no crash cart in the resident's room or hallway. According to the complainant, the Director of Nursing (EI #2) stated the nurse (later identified as EI #1) got into trouble for not calling the ambulance.
RI #1 was admitted to the facility on [DATE].
RI #1's ADVANCE DIRECTIVE ACKNOWLEDGEMENT form signed by RI #1's daughter dated [DATE] indicated RI #1 had not executed an
Advance Directive; therefore, RI #1 was a Full Code.
In a telephone interview on [DATE] at 5:30 PM, RI #1's daughter stated she received a phone call on [DATE] at 4:17 PM from EI #1 (LPN), who stated RI #1 was barely breathing and that CPR had been attempted. According to RI #1's daughter, when she arrived at the facility at 4:50 AM, she did not see a crash cart in RI #1's room nor did she see any staff. RI #1's daughter stated the Director of Nursing (EI #2) told her the ambulance was not called and the nurse, EI #1, got into trouble for not calling the ambulance.
In a telephone interview on [DATE] at 2:55 PM, EI #8, a CNA stated a little after 3:00 AM (on [DATE]) she notified the nurse, EI #1, who was at the nurses' station, that she might want to come and check on RI #1.
In a telephone interview on [DATE] at 10:40 AM, EI #1, a LPN, acknowledged she provided care to RI #1 on [DATE]. When asked about the events that took place with RI #1 on [DATE], EI #1 stated EI #8 (CNA) told her to come and check RI #1's vital signs. EI #1 stated when she went to RI #1's room to check the resident's vital signs, the resident's pulse was very faint. EI #1 left RI #1's room to call EI #3, a Registered Nurse, the physician and RI #1's family. EI #1 stated she returned to RI #1's room and began CPR by doing chest compressions for as long as she could. EI #1 was asked, how long she performed CPR and she stated she was not sure. When asked if she called a code, EI #1 said No, I did not. When asked if she called an ambulance (activate EMS), EI #1 said no ma'am. EI #1 was asked, what the facility's policy directed her to do when she found a resident unresponsive. EI #1 replied, to call a code, call (activate) the emergency response system and continue

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F 0309

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
CPR until EMS arrives. When asked if she followed the facility's policy, EI #1 said no. When asked if she used the crash cart, EI #1 said no. EI #1 was asked if she was CPR certified and she said no, her certification expired in [DATE]. EI #1 stated a couple of days later after RI #1 expired in the facility, the DON (EI #2) re-educated her about calling a code and the ambulance. When asked, why she did not call 911, EI #1 stated she was trying to get RI #1 back and she didn't think to call 911. EI #1 further stated, In hindsight, I should have called 911. When asked, how she knew RI #1 was dead, EI #1 stated she could not get a pulse or vital signs on RI #1; RI #1's nails were starting to turn purple and the resident was unresponsive. EI #1 acknowledged the facility has an AED; however, she did not use it. EI #1 was asked if she had performed CPR on other residents in the facility. EI #1 said yes. When asked about the incident, EI #1 stated it was similar to RI #1, that an unidentified Certified Nursing Assistant (CNA) found the resident unresponsive. EI #1 stated she performed CPR but was unable to resuscitate the resident. When asked if she called a code, EI #1 said no. EI #1 stated no one assisted her, that she was all alone. EI #1 also acknowledged that she did not use the crash cart. When asked, who the resident was, EI #1 said it was RI #2.

RI #2 was admitted to the facility on [DATE]. RI #2's electronic nurses' note written by EI #1 dated [DATE] entered at 8:22 AM documented . 0600 (6:00 AM) Resident found in bed unresponsive, unable to palpate pulse or B/P (blood pressure) chest not rising and falling; skin cool to touch . CPR attempted but unsuccessful .

In an interview on [DATE] at 9:00 AM, EI #1 was asked if she called 911 when she found RI #2 unresponsive on [DATE]. EI #1 said no. According to EI #1, her CPR certification expired April or [DATE].

In an interview on [DATE] at 11:20 AM, EI #5, who has been employed for two years as the Staffing Coordinator, was asked who was responsible for monitoring CPR certification. EI #5 stated she was. When asked about EI #1's lack of CPR certification, EI #5 stated when she interviewed EI #1, she asked for a copy but EI #1 stated it was in her other wallet and that she (EI #1) would bring it in. EI #1 then came to EI #5 later and said she couldn't find her CPR certification card. EI #5 told EI #1 to sign up for the next class, which was being held [DATE]. According to EI #5, EI #1 signed up for the class but did not show up. EI #5 was asked if she reported EI #1's lack of CPR certification to anyone and she said no.

In a follow-up interview on [DATE] at 8:10 AM, EI #1 stated when she entered RI #1's room, the resident had very shallow movements and a faint radial pulse. After noticing this, EI #1 left the resident's room to call the physician, RI #1's daughter and the Registered Nurse (RN), EI #3. When asked if she spoke with the physician, EI #1 stated no, it went to a pager and she left the facility's number for the physician to call back. EI #1 stated while she was talking with RI #1's daughter, she asked for verification purposes, what the resident's code status was. When asked if she knew the resident's code status, EI #1 said no, it was confusing. I was trying to pull it up on system. EI #1 was asked, how she called for RN (EI #3). EI #1 called from station to station on the intercom system. When asked, what she told EI #3, EI #1 said she told EI #3, the RN, that RI #1's vitals were faint. According to EI #1, she went back to RI #1's room and tried to arouse the resident but she could not feel a pulse or anything. Then, EI #1 lowered the resident's bed and started chest compressions. EI #1 stated she did 30 chest compressions, then check for a pulse. When asked, if any staff member was in RI #1's room with her, EI #1 stated not that I can remember. EI #1 was asked, if the physician called her back. EI #1 explained, as she was on her way back to the nurses' station, someone (name unknown) said the physician was on the phone. When asked, what the physician said, EI #1 said the physician said stop CPR and release RI #1's body to the funeral home. EI #1 acknowledged that she had already stopped CPR by the time the physician called back to tell her to stop CPR. When asked, if a nurse can just stop CPR when she wants to, EI #1 said no. EI #1 was asked, approximately what time did this event occur and she said somewhere between 3:00 AM - 4:00 AM.

EI #1's handwritten statement dated [DATE] documented On [DATE] I was told by the CNA that I needed to come check (RI #1) because (he/she) was unresponsive and said CNA could not get vital signs on (him/her). The time was 0400 (4:00 AM). I went in and tried to palpate a pulse (radial & carotid). I found a faint pulse and shallow rise and fall of the chest. I then called for assistance of a RN on duty at that time. I called the daughter and the doctor to inform them of the situation. I returned to the room and couldn't palpate a pulse and didn't see any movement of the chest or abdominal region. I called again to let the RN know what was happening and returned to (RI #1) and attempted CPR . (RI #1's) nail beds were purple in color and (his/her) hands were cool to touch. (The physician) called after 0500 (5:00 AM) and said to stop CPR and gave order to release body to the funeral home. The RN did not come down to assist me with what to do.

RI #1's electronic nurses' note written by EI #1 dated [DATE] entered at 4:39 AM (written 21 minutes before the physician called back to inform the staff to stop CPR) documented . 0400 (4:00 AM) unable to palpate vital signs, skin cool to touch finger tips purple. CPR attempted without success. (The physician) paged, order given to stop code and release body to funeral home of family's choice, daughter notified, stated they are on their way.

EI #3's handwritten statement dated [DATE] documented On [DATE]th, 2015, at about 4:10am, I was working at 100 hall with another nurse. Phone rang and the other nurse answered the call. When I asked what the call was all about, she told me the nurse at 200 hall stated that a resident was found dead. Then I decided to go over there to help out. I met the nurse at nursing station, she stated the resident had a weak pulse so she started CPR. So I went to the resident's room with the nurse and listened to the resident and no vital signs heard, no BP (blood pressure), no respiration, and no apical pulse heard. So I asked her to call (the physician), she said she had already called and waiting for him to call back. While we were at the nursing station the family members started coming in, so we went there with them, by then post morten (mortem) care has already been done and resident was laying on (his/her) back. We expressed our sympathy and I went back to the nursing station. Helped (with) the paperwork and went back to 100 hall.

In a telephone interview on [DATE] at 2:45 PM, EI #3, a Registered Nurse (RN) acknowledged she was working in the facility on the morning RI #1 expired ([DATE]). According to EI #3, she and another RN (EI #4), were working on the 100 hall, when EI #4 answered the phone and was told by EI #1 that RI #1 had expired. EI #3 stated about five minutes had passed when she went over to the 100 hall, where she saw EI #1 at the nurses' station. According to EI #3, EI #1 told her she had already done CPR. After finding out the resident's code status, EI #3 stated she went to RI #1's room, where she found the CNAs already performing post mortem care. EI #3 stated she listened with a stethoscope for vital signs and there were none; the resident had expired. EI #3 stated she told EI #1 to call the doctor and the family but EI #1 stated she had already done that. When asked, what the facility's process was for calling a code, EI #3 stated overhead page, code blue to the resident's room. EI #1 further stated That was not done that night. She (EI #1) just called us (EI #3 and EI #4) on the phone (and) said she needed help. When asked, how long should the code be done, EI #3 stated until EMS comes, but they didn't come because no one called them.

EI #4's handwritten statement dated [DATE] documented On [DATE]th, 2015 around 0410 (4:10 AM) I was working on the 100 Hall with another RN and I received a call from the LPN working on the 200 Hall stating she has a patient that died . I informed the RN working with me about the situation on the 200 Hall. The RN then left for the 200 Hall to assist the LPN.

In a telephone interview on [DATE] at 4:30 PM, EI #4, the other RN, stated she was working on the 100 hall with EI #3 when EI #1 called and said RI #1 had passed. EI #4 stated she did not go over to 200 hall but EI #3 did. EI #4 stated there was no overhead code called. When asked, what the facility's process was for calling a code, EI #4 stated overhead code blue to whatever room and everyone will come to offer assistance. When asked, how long should the code be done, EI #4 stated until we get assistance from EMS.

In an interview on [DATE] at 2:40 PM, EI #2, the Director of Nursing stated EI #1 (LPN) told her she did not call a code or EMS when RI #1 expired on [DATE]. EI #2 acknowledged that she did tell RI #1's daughter this information.

EI #1's PERSONNEL ACTION dated [DATE] indicated on [DATE] EI #1's employment with the facility was separated (terminated) on
[DATE] for failure to follow nursing procedure.

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On [DATE] at 10:40 AM, the facility submitted an acceptable Allegation of Credible Compliance, which documented . F309 . The Physician for each Resident effected (RI# 1&2) was notified on [DATE] by the DON that the facility failed to follow the American Heart Association guidelines for providing CPR for residents with full code status.

On [DATE] the Facility implemented a CPR policy that follows the recommendation of the American Heart Association that was reviewed and approved by the Medical Director and the Quality Assurance Team.

On [DATE] the facility Nursing Department was in-serviced on the CPR policy. As of [DATE] there are 7 nursing staff members that were unable to attend the in-service. Those staff members were notified by phone that they were removed from the schedule until the in-service was complete.

On [DATE] the CPR policy was added to the new hire orientation process.

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) AOC [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 309 was lowered to F level on [DATE] at 6:15 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 869.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**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 interviews and record review, Employee Identifier (EI) #6, the Administrator, who is responsible for directing the overall day-to-day operations of the facility and EI #2, the Director for Nursing, who is responsible for managing the nursing department, failed to ensure a system was in place for staff to readily identify a resident's code status. The resident's code status was documented in the computer, located at the nurses' station. Furthermore, EI #5, the Staffing Coordinator, who is responsible for directing the overall operation of education programs, failed to ensure licensed nurses maintained current Cardiopulmonary Resuscitation (CPR) certification. These deficient practices affected RI #1 and RI #2, two of two sampled residents reviewed for emergency response, with the potential to affect the remaining 63 Full Code status residents who reside in the facility. These deficient practices placed RI #1 and RI #2 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 has a total of 78 residents. A typed statement on facility letterhead, signed by the Administrator (EI #6) documented [DATE] Millennium Nursing and Rehab has 63 residents that are a Fullcode status . On [DATE] at 6:15 PM, the facility's Administrator, Director of Nursing, and two Regional Nurse Consultants were notified of the findings of immediate jeopardy in the area of Administration, F 490. Findings include: 1) The Administrator, EI #6's undated JOB DESCRIPTION documented . Summary: The purpose of this position is to establish and direct the facility's overall day-to-day operation, both internal and external, and coordinate these operations in accordance with current existing federal, state and local standards . ESSENTIAL DUTIES AND RESPONSIBILITIES: . *Develop, maintain and periodically update policies and procedures that govern that day-to-day functions of the facility . *Monitor procedures to assure compliance with the guidelines of state and federal regulations and facility policies . The Director of Nursing, EI #2's undated JOB DESCRIPTION documented . Summary: The purpose of this position is to manage the nursing department and administer the nursing programs in compliance with state and federal regulations as well as company policy and procedures. ESSENTIAL DUTIES AND RESPONSIBILITIES: *Plan, develop, organize, implement, evaluate and direct the Nursing Services Department . *Develop, maintain and periodically update written policies and procedures that govern the day-to-day functions of the nursing department . Cross reference F 309 In a telephone interview on [DATE] at 2:55 PM, EI #8, the Certified Nursing Assistant (CNA) who was assigned to care for RI #1 and alerted the nurse (EI #1) of RI #1's change in condition on [DATE], stated they (nursing staff) were running around like chickens with their heads cut off trying to find out the code status of RI #1. In a telephone interview on [DATE] at 10:40 AM, EI #1, the Licensed Practical Nurse (LPN) assigned to care for RI #1 on [DATE], was asked how she knew the code status of RI #1. EI #1 stated she looked for it in the computer but could not find it. In a follow-up interview on [DATE] at 8:10 AM, EI #1 stated while she was talking with RI #1's daughter, she asked for verification purposes, what the resident's code status was. When asked if she knew the resident's code status, EI #1 said no, it was confusing. I was trying to pull it up on (the) system. In a telephone interview on [DATE] at 2:45 PM, EI #3, the Registered Nurse (RN) who EI #1 called for assistance, stated when she arrived to the 200 hall nurses' station, she found EI #1 at the nurses' station. EI #3 said she asked EI #1 if RI #1 was a Full Code. According to EI #3, EI #1 told her she didn't know, that she had looked everywhere and couldn't find it. EI #3 stated she and EI #1 looked in the chart. EI #3 further stated that she looked also and couldn't find it. When asked, how she determined who was a Full Code, EI #3 stated, Most of the time it is in the computer, sometimes it's there, sometimes it's not. The nurse is hindered to know what to do - I just go ahead (and) do the CPR (and) will look later - But right now, since (RI #1) died , they have made a book now that's all the names of the residents on each wing that is full code or DNR. The way we have it now - we just look in the book (and) check - it is much easier. In a telephone interview on [DATE] at 4:30 PM, EI #4, a RN was asked how she determined who was a Full Code. EI #4 stated At that time (when RI #1 died) we had to look up in the computer but it was difficult to find, but (after) that incident they have a better system. Now we have a binder that is on top (of) the crash cart itself. In an interview on [DATE] at 10:45 AM, EI #2, the Director of Nursing was asked, prior to [DATE] how did the staff determine a resident's code status. EI #2 stated they would go into the computer. When asked about the code status book, EI #1 stated I put the code status book in place because of the confusion surrounding the (RI #1's) case, so they could have a backup to easily find full code or DNR . In an interview on [DATE] at 8:15 AM, EI #6, the Administrator was asked, what corrective measures the facility put in place since the incident involving RI #1 on [DATE]. EI #6 stated, a new policy was developed, the staff was in-serviced and they put together an easily identifiable book for reference. EI #6 explained this book will help the staff to readily identify the code status of a resident. 2) The Staffing Coordinator, EI #5's undated JOB DESCRIPTION documented . Summary: The purpose of this position is to plan, organize, develop and direct the overall operation of education programs for facility staff in accordance with current existing federal, state and local standards, and established policies and procedures of the facility. ESSENTIAL DUTIES AND RESPONSIBILITIES: . *Maintain accurate inservice attendance and other relevant records such as license/certificate renewal dates . MARGINAL DUTIES AND RESPONSIBILITIES: . *Review and determine validity of licensed and/or certified personnel for meeting the requirements of state and/or federal requirements . Cross reference F 309 In a telephone interview on [DATE] at 10:40 AM, EI #1, the Licensed Practical Nurse (LPN) who performed CPR on RI #1 on [DATE], was asked if she was CPR certified. EI #1 answered no and explained that her certification expired [DATE]. EI #1 was asked if she had performed CPR on other residents. EI #1 said yes. When asked about the incident, EI #1 stated it was similar to RI #1, that an unidentified Certified Nursing Assistant (CNA) found the resident unresponsive. EI #1 stated she performed CPR, but was unable to resuscitate the resident. When asked if she called a code, EI #1 said no. EI #1 stated no one assisted her, that she was all alone. EI #1 also acknowledged that she did not use the crash cart. When asked, who the resident was, EI #1 said it was RI #2. RI #2 was admitted to the facility on [DATE]. RI #2's electronic nurses' note written by EI #1 dated [DATE] entered at 8:22 AM documented . 0600 (6:00 AM) Resident found in bed unresponsive, unable to palpate pulse or B/P (blood pressure) chest not rising and falling; skin cool to touch . CPR attempted but unsuccessful . In a follow-up interview on [DATE] at 9:00 AM, EI #1 was asked if she called 911 when she found RI #2 unresponsive on [DATE]. EI #1 said no. According to EI #1, her CPR certification expired April or [DATE]. A review of EI #1's personnel file indicated EI #1's hire date with the facility was [DATE]. In an interview on [DATE] at 11:20 AM, EI #5, who has been employed for two years as the Staffing Coordinator, was asked who was responsible for monitoring CPR certification. EI #5 stated she was. When asked about EI #1's lack of CPR certification, EI #5 stated when she interviewed EI #1, she asked for a copy but EI #1 stated it was in her other wallet and that she (EI #1) would bring it in. EI #1 then came to EI #5 later and said she couldn't find her CPR certification card. EI #5 told EI #1 to sign up for the next class, which was being held [DATE]. According to EI #5, EI #1 signed up for the class, but did not show up. EI #5 was asked if she reported EI #1's lack of CPR certification to anyone and she said no. When asked if she had a policy or some sort of guideline to check new hire credentials, EI #5 said, No, it's pretty much in my head. In an interview on [DATE] at 10:45 AM, EI #2, the DON stated she was not aware that EI #1 was not CPR certified. EI #2 stated she found out yesterday ([DATE]) that EI #1's CPR certification was not current. EI #2 stated she was not aware that EI #1 did not call a code or activate the emergency response system when EI #1 found RI #2 without a pulse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **015458**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/24/2015**

NAME OF PROVIDER OF SUPPLIER **MILLENNIUM NURSING & REHAB CENTER, INC**	STREET ADDRESS, CITY, STATE, ZIP **5275 MILLENNIUM DRIVE HUNTSVILLE, AL 35806**

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 0490

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 4)
In an interview on [DATE] at 3:10 PM, EI #9, the Medical Director was asked if he expected the nurse to be certified that performed CPR. EI #9 said yes. When asked, if he was aware that the nurse (EI #1) who performed CPR on RI #1 was not CPR certified, EI #9 said No I was not aware.
****
On [DATE] at 10:40 AM, the facility submitted an acceptable Allegation of Credible Compliance which documented . F 490 . #1 Regional Nurse Consultants initiated the new CPR policy on [DATE] and CPR Directive to licensed staff and Admission Coordinator or designee to be initiated by the Admission Coordinator upon review with the resident and/or Responsible party in the admission packet. Once Directive is obtained then the Admission Coordinator is to notify the Charge Nurse for MD notification and orders as directed. If the MD gives an order for [REDACTED]. When the process is completed it automatically updates to the Nurse Manager Role to do list in Vision that the Advance directive has been updated so that review can occur in morning QA daily Monday through Friday.
RNC in-serviced the SDC, DON and Administrator on the adopted CPR policy and CPR Directive procedure put in place on [DATE].
The Administrator and Regional Director of Operations have contacted an outside independent consultant on [DATE] to oversee facility compliance.
#2 The SDC was in-serviced on [DATE] by Regional Nurse Consultant on ensuring that licensed nurses maintain current CPR certification for duration of employment.
An audit was completed on [DATE] of all licensed nurses to determine current status of CPR certification.
CPR certification classes were conducted on [DATE] and [DATE] with completion of all licensed nurses certification. The CPR classes were conducted by the Respiratory Therapist through the American Heart Association.
#3 DON or designee initiated in-service to CPR certified staff on proper code procedures for patients who are without a pulse or respirations on [DATE].
DON will conduct mock codes to observe clinical staff's response and to ensure CPR policy is being followed; every shift, every week for 3 weeks and randomly thereafter and report findings to QA committee.
DON will audit documentation of every resident who expires in the facility to ensure appropriate procedures were followed and notifications made.
AOC [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 490 was lowered to F level on [DATE] at 6:15 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 869.

F 0520

Level of harm - Immediate jeopardy

Residents Affected - Many

Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interviews and record review, the facility's Quality Assurance & Assessment (QA&A) Committee failed to develop and implement a corrective action plan after Resident Identifier (RI) #2 was found unresponsive by Employee Identifier (EI) #1, a Licensed Practical Nurse (LPN) on [DATE]. On [DATE], EI #1, a LPN, who was not certified to perform Cardiopulmonary Resuscitation (CPR), initiated and stopped CPR without calling a code in the facility, activating Emergency Medical Services (EMS) or notification from the physician.
Without a corrective action plan, on [DATE], EI #1, who still remained uncertified in CPR, initiated and stopped CPR on RI #1 without calling a code, activating EMS or notification from the physician.
These deficient practices affected RI #1 and RI #2, two of two sampled residents reviewed for emergency response, with the potential to affect the remaining 63 Full Code status residents who reside in the facility. These deficient practices placed RI #1 and RI #2 in immediate jeopardy because it was likely to cause serious injury, harm or death.
On [DATE] at 6:15 PM, the facility's Administrator, Director of Nursing, and two Regional Nurse Consultants were notified of the findings of immediate jeopardy in the area Quality Assurance and Assessment, F 520.
Findings include:
Page 11 of the Director of Nursing Training Manual titled QUALITY PROGRAM dated [DATE], documented GENERAL INFORMATION This
facility follow the evidence-based path to quality as outlined in the Quality Program Manual. The programs's systems provide easy tracking of quality measures along with the ability to review comparisons and trends within your facility. The methodology is designed to assess the quality of services provided. The program utilizes quality indicators to monitor and evaluate the quality of services provided. It must be a continuous process of identification, evaluation, implement of corrective action plans and monitoring.
RI #1 was admitted to the facility on [DATE]. RI #1's electronic nurses' note written by EI #1 dated [DATE] entered at 4:39 AM (written 21 minutes before the physician called back to inform the staff to stop CPR) documented . 0400 (4:00 AM) unable to palpate vital signs, skin cool to touch finger tips purple. CPR attempted without success. (The physician) paged, order given to stop code and release body to funeral home of family's choice, daughter notified, stated they are on their way. (Refer to F 309).
RI #2 was admitted to the facility on [DATE]. RI #2's electronic nurses' note written by EI #1 dated [DATE] entered at 8:22 AM documented . 0600 (6:00 AM) Resident found in bed unresponsive, unable to palpate pulse or B/P (blood pressure) chest not rising and falling; skin cool to touch . CPR attempted but unsuccessful .
In a telephone interview on [DATE] at 10:40 AM, EI #1 was asked if she had performed CPR on other residents. EI #1 said yes. When asked about the incident, EI #1 stated it was similar to RI #1, that an unidentified Certified Nursing Assistant (CNA) found the resident unresponsive. EI #1 stated she performed CPR, but was unable to resuscitate the resident. When asked if she called a code, EI #1 said no. EI #1 stated no one assisted her, that she was all alone. EI #1 also acknowledged that she did not use the crash cart. When asked, who the resident was, EI #1 said it was RI #2.
In a follow-up interview on [DATE] at 9:00 AM, EI #1 was asked if she called 911 when she found RI #2 unresponsive on [DATE]. EI #1 said no. According to EI #1, her CPR certification expired April or [DATE].
In an interview on [DATE] at 10:45 PM, EI #2, the Director of Nursing, stated she was not aware that EI #1 did not call a code or activate the emergency response system when EI #1 found RI #2 without a pulse.
In an interview on [DATE] at 8:15 AM, EI #6, the Administrator was asked if the facility reviewed the events surrounding RI #1's and RI #2's death in the facility. EI #6 replied, We did not review in QA.
According to the QUARTERLY LEADERSHIP TEAM QA/QI (Quality Improvement) Agenda and Minutes on [DATE] (five days after a LPN,
EI #1, who was not CPR certified, performed CPR on RI #2) at 4:00 PM, the concerns identified by the committee were: infection control, food temperatures and resident trust funds.
****
On [DATE] at 10:40 AM, the facility submitted an acceptable Allegation of Credible Compliance, which documented . F520 . A special session of the QA committee was held on [DATE] by the Administrator. The committee discussed and reviewed the results of the complaint survey as expressed during the exit with review of the immediate jeopardy deficiencies that included: Failure to honor advance directives; to follow American Heart Association guidelines for providing CPR; management failure to ensure that a system was in place so that all staff could readily identify code status; failure to ensure licensed nurses maintain current CPR certification; DON (Director of Nurses) failure to provide oversight to licensed nurses to respond appropriately to residents without a pulse or respirations; Regional Nurse Consultants failed to ensure the facility had a system in place which directed the staff on how to respond if they found a resident without a pulse and respirations; failure of the QA committee to develop and implement corrective action for RI #1 and RI #2 who were a full code and the nurse initiated and ceased CPR without activating the emergency medical service and the physician. The QA committee will discuss survey results and modify systems as needed to maintain compliance.
The QA committee received in-service training by the Administrator and Regional Nurse Consultant on [DATE] and [DATE]. The in-service included but was not limited to: Facility QA policies and procedures; Daily QA morning meetings; monthly QA meetings (Leadership team; Customer Service; Patient Care and Services; Behavior and Pain Management) Quarterly QA (goal

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLENNIUM NURSING & REHAB CENTER, INC	**5275 MILLENNIUM DRIVE HUNTSVILLE, AL 35806**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) setting, brainstorming, root cause analysis). The QA committee was instructed to call a meeting to address concerns identified as they arise as well as during the above meetings as needed with assistance from the Medical Director to resolve, reduce, or eliminate concerns identified. The EI #1 received in-service training on [DATE] and [DATE] by the Director of Nursing and Regional Nurse Consultant. The in-service covered areas but not limited to: Advance Directives, Code Status, CPR, (The facility will follow The American Heart Association), Code Blue, and activation of Emergency Medical Services. On [DATE] EI #1 was removed from the schedule indefinitely by the DON. On [DATE] EI #1 employment was terminated. The Administrator has reached out to AQAF on [DATE] and enrolled in the quality improvement program. The Administrator and Regional Director of Operations have contacted an outside independent consultant on [DATE] to oversee facility compliance. AOC [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 520 was lowered to F level on [DATE] at 6:15 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 869.