STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING _____ B. WING _____	**05/11/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	**200 GLENWAY ROAD WINCHESTER, KY 40391**

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 0655 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility's policy, it was determined the facility failed to ensure the Baseline Care Plan was implemented to provide effective and person-centered care for one (1) of ten (10) sampled residents (Resident #1). Resident #1's Baseline Care Plan, dated [DATE], revealed the resident and family had chosen a code status of Full Code, meaning in the event the resident experienced a cardiopulmonary arrest, Cardiopulmonary Resuscitation (CPR) was to be performed. However, on [DATE], per staff interview, at approximately 5:45 PM, when Registered Nurse (RN) #1 observed Resident #1 to be unresponsive and cold to the touch with absence of respirations and heartbeat, she failed to immediately check the medical record for code status, and initiate CPR as she did not know the facility's protocol when a resident was found unresponsive. RN #1 consulted with Licensed Practical Nurse (LPN) #1 on facility protocol, and then overhead paged for a nurse from other units to call Unit B Hall immediately. Subsequently RN #1 called the DON who instructed her to to check the resident's code status, call 911, get the crash cart, and code the resident. RN #1 called 911, and initiated CPR at approximately 6:08 PM, which was approximately twenty-three (23) minutes after the resident was found with absence of respirations and heartbeat. However, RN #1 only performed three (3) to five (5) chest compressions before stopping CPR and staff interviews revealed no other staff continued with the CPR. Record review revealed staff were not performing CPR when Emergency Medical Services (EMS) arrived. EMS transported the resident to the Hospital emergency room and Resident #1 was pronounced dead on [DATE] at 6:53 PM. (Refer to F-678) The facility's failure to have an effective system in place to ensure staff implement the Baseline Care Plan to provide effective and person-centered care has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE] and determined to exist on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. However, the State Survey Agency (SSA) determined the Immediate Jeopardy was not removed on [DATE] as alleged. Through record review, the SSA identified discrepancies regarding code status related to Advance Directives, physician's orders [REDACTED]. The facility made corrections and conducted another audit on [DATE]. Therefore, the SSA determined the Immediate Jeopardy was not removed until [DATE]. Non-compliance remains at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's Baseline Care Plan Policy, undated, revealed a Baseline Plan of Care shall be developed for each resident within forty-eight (48) hours of admission. Continued review revealed the Baseline Care Plan would include the minimum healthcare information necessary to properly care for a resident including, but not limited to: initial goals based on admission orders [REDACTED]. Review of Resident #1's clinical record revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Advance Directive/Informed Consent Form, signed by the resident's son on [DATE], revealed Full Code, which indicated in the event the resident experienced a cardiopulmonary arrest, Cardiopulmonary Resuscitation (CPR) was to be performed. Review of Resident #1's (MONTH) (YEAR) physician's orders [REDACTED].>Review of Resident #1's Baseline Care Plan, dated [DATE], revealed the resident and family had elected Full Code. Review of the Progress Note, dated [DATE] at 6:28 PM, signed by RN #1, revealed RN #1 entered Resident #1's room to pick up the dinner tray, and the resident was noted to be unconscious and did not respond to word or touch. Per the Note, Resident #1's skin was cold and his/her eyes were open. Further review of the Note, revealed RN #1 placed the resident in a lying position and started CPR; and LPN #1 quickly replaced RN #1 in order for RN #1 to call 911 and the family. Per the Note, CPR continued and EMS arrived and took over life resuscitation attempts. However, review of the facility's Investigation Report, completed by the Administrator, dated [DATE], revealed RN #1 initiated CPR to Resident #1 after speaking with the DON by phone and after being instructed to do so. Per the Report, RN #1 stated she initiated CPR, but became confused and called the resident's son to inform him of the resident's condition. The Report further stated, while RN #1 was on the phone with the resident's son, EMS arrived and took over CPR and transported the resident to the hospital. Review of Resident #1's Emergency Medical Response Report, dated [DATE], revealed EMS received a call on [DATE] at 6:08 PM; and arrived on scene at 6:14 PM to find Resident #1 in [MEDICAL CONDITION]. Further review of the Report, revealed on EMS arrival, the nurse was at the nurse's station with no efforts being made for CPR, no one was with the resident, and the resident appeared to have been dressed and posed. EMS left the scene at 6:34 PM and CPR was discontinued at 6:55 PM. Interview on [DATE] at 6:20 PM with RN #1, revealed when she found the resident not breathing and cold to the touch, she thought the resident had passed away and asked LPN #1 what she should do. Per interview, LPN #1 told her she needed to call the DON, and she and LPN #1 then went to the nurse's desk because neither one of them knew the protocol of what to did if they found a resident unresponsive. Interview on [DATE] at 12:15 PM, with LPN #1, revealed on [DATE] at approximately 5:30 PM, RN #1 called out to her and told her a resident had died and she wanted her to check to ensure the resident was deceased . LPN #1 stated upon entering Resident #1's room she observed the resident sitting up in the bed with eyes slightly open, and chest not moving and she touched the resident's hand which was cold. She further stated neither she or RN #1 checked to see if Resident #1 had a pulse or respirations, but left the room to go to the nurse's station to call the DON. Continued interview revealed she and RN #1 should have checked Resident #1's chart for code status, and should have called a code blue when they found the resident unresponsive. She stated Resident #1's Baseline Care Plan should have been followed related to code status. Further interview with RN #1, on [DATE] at 6:20 PM, revealed she was in a panic mode and called the DON and was told to go do a code. Per interview, RN #1 went to the resident's room to initiate CPR. She stated she pushed on the resident's chest about three (3) or four (4) times and stopped because the resident was cold and she felt like it was wrong to continue with CPR due to it had been about twenty (20) minutes since she initially found the resident unresponsive. Further interview revealed after she left the resident's room, nobody was performing CPR on the resident. Per interview, she should have initiated CPR immediately and once she initiated CPR, she should have continued CPR until EMS arrived. Further interview revealed the resident's Baseline Care Plan stated the resident/s code status was Full Code, and the Care Plan should have been followed. Interview on [DATE] at 3:03 PM, with the DON, revealed RN #1 called her on [DATE] at 6:07 PM, stating Resident #1 had passed

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 0655 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) away. The DON stated the resident had not been at the facility long and she thought the resident was a Full Code, but told RN #1 to check the code status. Per interview, when RN #1 informed her the resident was a Full Code she instructed RN #1 to perform CPR. The DON stated RN #1 told her it's too late, and she (DON) instructed RN #1 to perform CPR because Resident #1 was a Full Code and to call EMS. She further stated RN #1 called back at 6:21 PM and informed her EMS had arrived and the resident was on the way to the Hospital emergency room . Further interview revealed RN #1 should have checked the resident's code status when she found the resident unresponsive with absence of respirations and heartbeat and immediately initiated CPR, and continued CPR until EMS arrived and transported the resident to the hospital. The DON further stated she expected staff to follow the Baseline Care Plan related to code status. Interview on [DATE] at 11:40 AM, with Resident #1's Attending Physician (AP), revealed he was informed on [DATE], that Resident #1 had expired. He stated he was aware the resident had been admitted to the facility on [DATE] with a Full Code status, but was unaware there was a delay in initiating CPR and was unaware staff had stopped CPR. Further interview revealed in the event a nurse found a resident unresponsive, he expected the nurse to follow the resident's Care Plan related to code status because it guided the resident's care. Interview on [DATE] at 3:33 PM, with the Administrator, revealed she was notified on [DATE] by the DON, Resident #1 had passed. She stated RN #1 failed to immediately verify the resident's code status by looking in Resident #1's chart and failed to initiate CPR in a timely manner. Also, she stated RN #1 failed to continue CPR until EMS arrived at the facility to assume care of the resident. The Administrator stated it was her expectation that staff follow the Baseline Care Plan related to code status in order to honor the resident's wishes. Review of the A[NAME] revealed the facility implemented the following: 1. An investigation related to Resident #1 and the incident which occurred on [DATE], was initiated on [DATE] and completed by [DATE], by the Director of Nursing (DON) and the Administrator. During the investigation a review of Resident #1's medical record, code blue process, and cardiopulmonary resuscitation process, staff interviews, and resident interviews was completed. It was determined by the facility there was a failure in following policies and procedures including the Cardiopulmonary Resuscitation Policy and Care Plan Policy. 2. Beginning on [DATE] and concluding on [DATE], the DON, Assistant Director of Nursing (ADON), Unit Managers, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Coordinator, Restorative Nurse Manager and Nursing Supervisor received Mock Code training by the Registered Nurse Consultant (RNC). 3. Beginning on [DATE] and concluding on [DATE], all Registered Nurses (RN) and Licensed Practical Nurses (LPN) received Mock Code training by the SDC. RNs and LPNs received a post test and had to obtain a score of one hundred percent (100%). RNs and LPNs who had not completed the required training by [DATE] would be notified by certified letter, that they would not be allowed to work until the Mock Code training had been completed. As of [DATE], a total of twenty-two (22) out of twenty-seven (27) nurses completed training. Five (5) PRN (as needed) nurses the facility was unable to contact were sent certified letters stating they would not be scheduled to work until training was completed and that training was mandatory. The education related to the policies and procedures was added to the training agenda for New Employee Orientation. The facility does not utilize agency staff. 4. Education related to Advance Directive Policy and Procedure, where Advance Directives were located in the clinical record, Admission/Physician order [REDACTED]. Certified letters were sent to the thirteen (13) staff members to notify them of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers Nursing Supervisors or RNC. All licensed staff received a post test and were required to attain a passing score of one hundred percent (100%). The education related to the policies and procedures was added to the training agenda for New Employee Orientation. The facility does not utilize agency staff. 5. On [DATE], all Department Managers were educated by the RNC on the Advance Directive Policy and Procedure, Admission/physician's orders [REDACTED]. Department Managers could not return to work until education had been completed. 6. Beginning on [DATE] and concluding on [DATE], the Social Service Director, DON, Unit Managers, and Nursing Supervisors assessed all residents to ensure all quality of care needs were being met. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations. 7. Beginning on [DATE] and concluding on [DATE], compliance audits of the admission process were completed on all admissions within the previous thirty (30) days. The audits were performed by the DON, Unit Managers or RNC of all resident's medical records to ensure compliance with the admission process to include reviewing admitting orders including Advance Directives/code status, and care plans. 8. On [DATE], an audit was conducted of all licensed nurse personnel files for CPR certification and licensure by the Staff Development Coordinator (SDC). 9. Beginning on [DATE] and concluding on [DATE], audits of all residents who expired within the previous sixty (60) days were performed by the RNC to ensure: Advance Directives were signed and witnessed to designate code status; Code Status was designated by Advance Directive; physician's orders [REDACTED]. 10. By [DATE], an audit was conducted by the RNC on all Emergency Code Documentation sheets for the previous thirty (30) days for compliance with CPR Policy. 11. By [DATE], an audit was conducted by the RNC of all Accidents and Incidents for the previous thirty (30) days to ensure all code blue processes were followed and within compliance with the CPR Policy. 12. The DON, Unit Managers, SDC, MDS Coordinator, Restorative Nurse Manager, or Nursing Supervisor will conduct an audit/review of care plans daily to ensure accuracy with code status along with implementation and individualization of the care plan and the SRNA care plan. The findings will be reviewed by the DON daily during the morning clinical white board meeting and discussed with the QAPI team during monthly QAPI meeting. 13. The DON, Unit Managers, SDC, MDS Coordinator, Restorative Nurse Manager, or Nursing Supervisor will conduct an audit/review Nurse's Notes, Social Service Notes, Accidents and Incidents, and the Twenty-Four (24) Hour Report daily to ensure any change in condition noted had appropriate interventions implemented and updated on the care plan. The findings will be reviewed by the DON daily during the morning clinical white board meeting and discussed with the QAPI team during monthly QAPI meeting. 14. The DON, Unit Managers, SDC, MDS Coordinator, Restorative Nurse Manager, or Nursing Supervisor will conduct an audit/review of all emergency code documentation sheets daily to ensure completeness, accuracy, and compliance with CPR Policy and Procedure along with the process. The findings will be reviewed by the DON daily during the morning clinical white board meeting and discussed with the QAPI team during monthly QAPI meeting. 15. By [DATE], the Unit Managers, Nursing Supervisors, and the DON conducted an audit of all in house residents' charts regarding Advance Directives to ensure they were signed, witnessed, current, complete and matched code status; Code Status to ensure current, complete, displayed in chart and matched physician's orders [REDACTED]. 16. On [DATE], a Quality Assurance Performance Improvement (QAPI) Meeting was held to review the Immediate Jeopardy (IJ) incident, initiation of the investigation, and current plan for the Medical Directors input, recommendations, and approval. Additional QAPI meetings were held on [DATE] and [DATE] to review the on-going plan, compliance, validation, and for any needed recommended changes to the plan. Findings of the daily audits will be reviewed by the DON daily during clinical white board meetings and discussed with QAPI team during monthly QAPI. QAPI meetings will be conducted monthly for three (3) months to review the effectiveness of the plan with progression through the plan. The State Survey Agency validated the implementation of the facility's A[NAME] on [DATE] as follows: 1. Review of the facility's investigation of the incident involving Resident #1 on [DATE], revealed an audit of Resident #1's medical record was completed on [DATE] with areas of concern noted. Interview with the DON, on [DATE] at 3:03 PM, revealed she audited Resident #1's medical record and assisted with the investigation related to Resident #1, and identified areas of concern with CPR Policy and Procedure, Advance Directive Policy and Procedure, Professional Standards, and the Care Plan Policy not followed. Per interview, there was immediate implementation of education to licensed nursing staff. 2. Review of the (MONTH) (YEAR) calendar documentation of Mock codes, revealed all nursing administration staff had received Mock Code training by the RNC by [DATE]. Continued review revealed all licensed nursing staff had received Mock code training by [DATE] by the SDC. Interview on [DATE] at 3:03 PM with the DON; [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM with the

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F 0655 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) SDC; [DATE] at 12:39 PM with the Reflections Unit Manager; [DATE] at 12:48 PM with the B Wing Unit Manager; and [DATE] at 2:38 PM with the A Wing Unit Manager; revealed they had received Mock code training in (MONTH) (YEAR) by the RNC. Interview on [DATE] at 12:54 PM with the RNC, revealed she had conducted Mock code training with all nursing administration staff. 3. Review of the (MONTH) calendar utilized to conduct mock code training for licensed nursing staff on 7:00 AM shift and 7:00 PM shifts, for two (2) weeks starting [DATE], revealed training had been conducted and reviewed by the DON for compliance weekly. Interview on [DATE] at 3:03 PM, with the DON, revealed mock code training for licensed staff on 7:00 AM shift and 7:00 PM shifts had been conducted for two (2) weeks starting [DATE] and reviewed by her for compliance weekly. Continued interview revealed the DON presented the audit findings to the monthly QAPI team meetings. Interviews on [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM with the SDC; [DATE] at 12:39 PM with the B Wing Unit Manager; [DATE] at 12:48 PM with the Reflections Unit Manager; [DATE] at 12:55 PM with the Restorative Nurse Manager; [DATE] at 1:18 PM with the MDS Coordinator; and [DATE] at 2:38 PM with the A Wing Unit Manager; revealed they had conducted mock code training for licensed staff on 7:00 AM shift and 7:00 PM shifts for two (2) weeks starting on [DATE]. Interview on [DATE] at 12:30 PM with LPN #1; [DATE] at 2:23 PM with LPN #8; [DATE] and at 3:05 PM with LPN #2; [DATE] at 12:55 PM with RN #4; [DATE] at 2:36 PM with RN #6; [DATE] at 4:25 PM with LPN #7; and [DATE] at 4:37 PM with LPN; revealed they had received Mock code training in (MONTH) (YEAR) by the SDC. 4. Review of the education provided to all licensed staff related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. Review of the POS [REDACTED]. Review of the New Hire Orientation Packet revealed the education related to the policies and procedures had been added to the training agenda for New Employee Orientation. Interview on [DATE] at 12:30 PM, with LPN #1; [DATE] at 2:23 PM with LPN #8; and [DATE] at 3:05 PM with LPN #2; revealed they had received education related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. Interview on [DATE] at 12:55 PM with RN #4; [DATE] at 2:36 PM with RN #6; [DATE] at at 4:25 PM with LPN #7; and [DATE] at 4:37 PM with LPN #8; revealed they had received education related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. 5. Review of the education provided to all Department Managers related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. Review of the POS [REDACTED]. Interview on [DATE] at 3:03 PM with the DON; [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM with the SDC; [DATE] at 12:39 PM with the Reflections Unit Manager; [DATE] at 12:48 PM with the B Wing Unit Manager; and [DATE] at 2:38 PM with the A Wing Unit Manager; revealed they had received education from the RNC on Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. Interview on [DATE] at 12:54 PM, with the RNC, revealed she had conducted re-education with all nursing administration staff related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. 6. Review of the facility's audit tool utilized to interview and assess all residents for possible resident rights violations, revealed the Social Services Director (SSD) interviewed all residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater; and a physical assessment was completed by Nursing Administration staff for residents whose BIMS was less than eight (8). The audit was completed on [DATE]. Interview on [DATE] at 3:03 PM, with the DON, revealed the SSD and nursing management staff interviewed or assessed each resident for any signs or symptoms of resident rights violations and quality of care issues. 7. Review of the audit tool utilized to audit the previous thirty (30) days of facility new admissions, revealed new admissions had been audited for compliance with admission process, Advance Directive/Code status, Care Plans, and review of New Admission physician's orders [REDACTED]. Interviews on [DATE] at 3:03 PM with the DON; [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:39 PM with the Reflections Unit Manager; [DATE] at 12:48 PM with the B Wing Unit Manager; [DATE] at 2:38 PM with the A Wing Unit Manager; and [DATE] at 2:54 PM, with the RNC, revealed they had participated with other management staff to audit all resident's records who were admitted to the facility in the previous thirty (30) days to verify accuracy of each resident's Advance Directive, Care Plan, and physician's orders [REDACTED]. 8. Review of the audit tool utilized to audit all licensed nurse personnel files for CPR certification and licensure, revealed the audit was completed on [DATE]. Interview on [DATE] at 12:10 PM, with the SDC, revealed she had conducted an audit of all licensed nurse personnel files to ensure compliance with CPR certification and licensure on [DATE]. 9. Review of the audit tool utilized to audit all residents who expired within the previous sixty (60) days to ensure Advance Directives were signed and witnessed to designate code status, code status was designated by Advance Directive, physician's orders [REDACTED]. Interview on [DATE] at 12:54 PM, with the RNC, revealed she had conducted an audit of all residents who expired within the previous sixty (60) days to ensure Advance Directives were signed and witnessed to designate code status, code status was designated by Advance Directive, Physician orders [REDACTED]. 10. Review of the audit tool utilized to audit all Emergency Code Documentation Sheets for the previous thirty (30) days to ensure completeness, accuracy, and compliance with CPR policy and procedure, revealed the audit was completed on [DATE]. Interview on [DATE] at 12:54 PM, with the RNC, revealed she had conducted and audit of all Emergency Code Documentation sheets for the previous thirty (30) days to ensure completeness, accuracy, and compliance with CPR Policy and Procedure on [DATE]. 11. Review of the audit tool utilized to audit all Accidents and Incidents for the previous thirty (30) days to ensure all codes blue processes were followed and within compliance with the CPR Policy and Procedure, revealed the audit was completed on [DATE]. Interview on [DATE] at 2:54 PM, with the RNC, revealed she had conducted an audit of all Accidents and Incidents to ensure code blue processes were followed and within compliance with the CPR Policy and Procedure on [DATE]. 12. Review of the audit tool utilized to conduct daily audit/review of care plans to ensure accuracy with code status along with implementation and individualization of the care plan and the SRNA care plan revealed audits were being completed daily by the nursing administration staff. Per review, the findings were presented by the DON in the morning white board meetings. Interview on [DATE] at 3:03 PM with the DON; [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM with the SDC; [DATE] at 12:39 PM with the Reflections Unit Manager; [DATE] at 12:48 PM with the B Wing Unit Manager; [DATE] at 12:55 PM with the Restorative Nurse Manager; [DATE] at 1:18 PM with the MDS Coordinator; and [DATE] at 2:38 PM with the A Wing Unit Manager, revealed they had participated in daily audit/review of care plans to ensure accuracy with code status along with implementation and individualization of the care plan and the SRNA care plan and the audits were completed daily. Continued interview revealed the DON presented the audit findings to the monthly QAPI team meetings. 13. Review of the audit tool utilized to conduct audit/review of Nurse's Notes, Social Service Notes, Accidents and Incidents, and the Twenty-Four (24) Hour Report daily to ensure any change in condition noted had appropriate interventions implemented and updated on the care plan, revealed audits were being completed daily by the nursing administration staff. Interview on [DATE] at 3:03 PM, with the DON, revealed she had participated in daily audit/review of Nurse's Notes, Social Service Notes, Accident and Incidents, and the Twenty-Four (24) Hour Report daily to ensure any change in condition noted had appropriate interventions implemented and updated on the care plan. Continued interview revealed the DON presented the audit findings to the monthly QAPI team meeting. Interviews on [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM with the SDC; [DATE] at 12:39 PM with the Reflections Unit Manager; [DATE] at 12:48 PM with the B Wing Unit Manager; [DATE] at 12:55 PM with the Restorative Nurse Manager; [DATE] at 1:18 PM with the MDS Coordinator; and [DATE] at 2:38 PM with the A Wing Unit Manager; revealed she they had conducted daily audit/review of Nurse's Notes, Social Service Notes, Accidents and Incidents, and the Twenty-Four (24) Hour Report to ensure any change in condition noted had appropriate interventions implemented and updated on the care plan. 14. Review of the audit tool utilized to conduct audit/review of all emergency code documentation sheets daily to ensure completeness, accuracy, and compliance with CPR Policy and Procedure, along with the process revealed the audits were being conducted daily by the nursing administration staff.

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F 0655 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) Interview on [DATE] at 3:03 PM, with the DON, revealed she had participated in daily audit/review of all emergency code documentation sheets to ensure completeness, accuracy, and compliance with CPR Policy and Procedure. Per interview, the audits were being conducted daily by the nursing administration staff. Continued interview revealed the DON presented the audit findings to the monthly QAPI team meetings. Interviews on [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM with the SDC; [DATE] at 12:39 PM with the Reflections Unit Manager; [DATE] at 12:48 PM with the B Wing Unit Manager; [DATE] at 12:55 PM with the Restorative Nurse Manager; [DATE] at 1:18 PM with the MDS Coordinator; and [DATE] at 2:38 PM with the A Wing Unit Manager; revealed they had conducted daily audit/review of all emergency code documentation sheets daily to ensure completeness, accuracy, and compliance with CPR Policy and Procedure along with the process revealed the audits were being conducted daily. 15. Review of the Audits, revealed a one hundred percent (100%) audit was conducted by the facility of all i (TRUNCATED)
F 0658 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policies, review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statements (AOS), and review of the American Heart Association Journal, Ethical Issues Around Out of Hospital Resuscitation, Withholding CPR at the Start versus Withdrawing CPR at the End, it was determined the facility failed to have an effective system in place to ensure services provided met professional standards of quality for one (1) of ten (10) sampled residents (Resident #1). The facility admitted Resident #1 on [DATE]. The resident had an Advance Directive/Informed Consent Form, which stated, Full Code. However, per staff interview and record review, on [DATE] at approximately 5:45 PM, Registered Nurse (RN) #1 observed Resident #1 to be unresponsive, with absence of respirations and heart rate, and the nurse failed to check the resident's code status and initiate Cardiopulmonary Resuscitation (CPR) immediately. RN #1 had been employed at the facility for two (2) months, but was unaware of facility protocol of what to do when finding a resident unresponsive and had not been oriented on initiating a code at the facility. At approximately 6:07 PM, RN #1 called the Director of Nursing (DON) who directed her to check the resident's chart for code status. When RN #1 identified the resident was a Full Code, the DON instructed the nurse to hang up the phone, call 911, grab the crash cart, and code the resident. RN #1 initiated CPR on [DATE] at approximately 6:08 PM which was approximately twenty-three (23) minutes after finding the resident unresponsive with no respirations and heartbeat. However, RN #1 performed three (3) to five (5) chest compressions, and then stopped. Review of the Emergency Medical Response Report revealed Emergency Medical Services received a call on [DATE] at 6:08 PM and arrived on scene at 6:14 PM to find Resident #1 in [MEDICAL CONDITION] with no efforts at CPR or oxygenation. EMS transported Resident #1 to the Hospital where the resident was pronounced dead on [DATE] at 6:53 PM. (Refer to F-678) The facility's failure to have an effective system to ensure services provided met professional standards of quality has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE], and determined to exist on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. However, the State Survey Agency (SSA) determined the Immediate Jeopardy was not removed on [DATE] as alleged. Through record review, the SSA identified discrepancies regarding code status related to Advance Directives, physician's orders [REDACTED]. The facility made corrections and conducted another audit on [DATE]. Therefore, the SSA determined the Immediate Jeopardy was not removed until [DATE]. Non-compliance remains at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's Cardiopulmonary Resuscitation Policy, undated, revealed CPR would be attempted for any resident who was found to have no palpable pulse and/or no discernible respirations, unless there was a written physician's orders [REDACTED]. Continued review revealed if a resident was found unresponsive and without respirations, a licensed staff member who was certified in CPR would promptly initiate CPR for residents who had requested CPR in their Advance Directive. Further review revealed CPR would be continued by the facility staff until EMS arrived to assume responsibility for providing CPR. Interview with the Administrator on [DATE] at 3:33 PM, revealed the facility did not use a specific professional standards of clinical practice, but used KBN Guidelines in providing care to the residents. Review of KBN, AOS #14, revised (MONTH) (YEAR), Roles of Nurses in the implementation of Patient Care Orders, revealed in accordance with Kentucky Revised Statutes (KRS) 314.021 (2), nurses were responsible and accountable for making decisions that are based upon the individual's educational preparation and current clinical competence in nursing and requires licensees to practice nursing with reasonable skill and safety. Further review revealed licensed nurses should administer medication and treatment as prescribed by the Physician, Physician Assistant, Dentist, or Advanced Practice Registered Nurse (ARNP). Review of the KBN's Advisory Opinion Statement (AOS) #36, Resuscitation, approved (MONTH) 2008, revealed nurse's were required to honor the Advanced Directives of patients who had the Advanced Directive documented in the medical record, unless a Physician or healthcare facility refused to comply and the patient and surrogate were informed of the refusal. Review of the American Heart Association Journal, Ethical Issues Around Out of Hospital Resuscitation, Withholding CPR at the Start versus Withdrawing CPR at the End, dated [DATE], revealed Basic Life Support (BLS) Training urges the average citizen responding first to a [MEDICAL CONDITION] to perform CPR. Healthcare professionals are expected to provide BLS and Advanced Cardiac Life Support (ACLS) as part of their professional duty to respond. The exceptions included: when a person lies dead, with no obvious clinical signs of irreversible death; when attempts to perform CPR would place the rescuer at risk of physical injury; and when the patient or surrogate has indicated that resuscitation is not desired. Review of Resident #1's medical record revealed the facility admitted the resident on [DATE]. Review of Resident #1's Advance Directive/Informed Consent Form, signed by the resident's son on [DATE], revealed Full Code, indicating in the event the resident experienced a cardiopulmonary arrest, the resident wanted CPR performed. Review of the resident's physician's orders [REDACTED]. Review of Resident #1's Progress Note, dated [DATE] at 6:28 PM, written by RN #1, revealed RN #1 entered the resident's room to pick up the dinner tray, and the resident was noted to be unconscious and didn't respond to word or touch. The Note further revealed Resident #1's skin was cold and his/her eyes were open. Additional review of the Note, revealed RN #1 placed the resident in a lying position and started CPR; and LPN #1 quickly replaced RN #1 in order for RN #1 to call 911 and the family. Continued review of the Note, revealed CPR continued and EMS arrived and took over life resuscitation attempts. Review of the facility's Investigation Report, completed by the Administrator, dated [DATE], revealed RN #1 gave Resident #1 his/her dinner tray at approximately 5:15 PM on [DATE]. Subsequently RN #1 returned to the resident's room at approximately 5:45 PM and found Resident #1 cold, with his/her eyes open, unresponsive, and CPR was initiated. EMS was called and the resident was transported to the hospital where he/she later expired. Continued review of the Investigation Report, revealed an interview was conducted with RN #1 who stated she initiated CPR to Resident #1 after speaking with the DON by phone, after being instructed to do so. Additional review revealed RN #1 stated she initiated CPR, but became confused and called the resident's son to inform him of the resident's condition. Per the Report, while RN #1 was on the phone talking with the resident's son, EMS arrived and took over CPR and transported the resident to the hospital. The investigation had no timeline of events. Review of Resident #1's Emergency Medical Response Report, dated [DATE], revealed EMS received a call on [DATE] at 6:08 PM; and arrived on the scene at 6:14 PM to find Resident #1 in [MEDICAL CONDITION]. Per the Report, the resident was in arrest for an unknown amount of time with no efforts at CPR or oxygenation; and the resident was unresponsive, warm to touch, and no lividity was noted. Additional review of the Report, revealed on EMS arrival, the nurse was at the nurse's station with no efforts being made for CPR, no one was with the resident, and the resident appeared to have been dressed and posed. The Report further revealed a right [MEDICAL CONDITION] tracheal tube and intraosseous line was placed, [MEDICATION NAME] (medication used as a heart stimulant), [MEDICATION NAME] (medication to relax muscles), and [MEDICATION NAME] (opioid antagonist) was given enroute as well as the Lucas Device was used for compressions, and EMS departed the scene at 6:34 PM and CPR was discontinued at 6:55 PM. Interview on [DATE] at 6:20 PM with RN #1, revealed she was assigned to Resident #1 on [DATE], and at approximately 5:45 PM

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F 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) she noticed his/her eyes were slightly open and he/she was cold to the touch. Per interview, she did not have her stethoscope with her, so she put her head on the resident's chest to see if he/she was breathing and he/she was not breathing. She stated she checked his/her mouth for food and did not find anything in the resident's mouth, and then checked the resident's pulse and noted there was no pulse. RN #1 stated she went to the door and yelled down the hall for LPN #1, who came to the room. RN #1 stated she told LPN #1 she thought the resident had passed away and asked LPN #1 what she should do and LPN #1 told her she needed to call the DON. Per interview, neither RN #1 or LPN #1 knew the facility's protocol for finding a resident unresponsive. Interview on [DATE] at 12:15 PM, with LPN #1, revealed RN #1 informed her a resident had died and she wanted her to check the resident. LPN #1 revealed she entered Resident #1's room and observed the resident sitting up in the bed with eyes slightly open, and chest not moving. LPN #1 stated she touched the resident's hand which was cold, but neither she (LPN) #1 or RN #1 checked to see if Resident #1 had a pulse or respirations. LPN #1 revealed she and RN #1 left the room to go to the nurse's station to call the DON and she verified no one was performing CPR on the resident at this time. Further interview with RN #1, on [DATE] at 6:20 PM, revealed she went to the nurses' station and called Unit A and Unit D to find out what the protocol was for finding a resident unresponsive and no one answered the phone so she overhead paged for a nurse from Unit A or Unit D to call the Unit B Hall immediately. RN #1 further stated LPN #2 returned the call and asked RN #1 about the resident's code status, and she checked the resident's chart and saw a sticker that said Full Code, and informed LPN #2 the resident was a Full Code. RN #1 stated LPN #2 told her, you are supposed to code {him/her}. Interview on [DATE] at 3:05 PM, with LPN #2, revealed she heard an overhead page for an RN or LPN to call B Wing immediately. LPN #2 revealed she responded to the page, and RN #1 answered the phone. LPN #2 further revealed RN #1 asked her of it took two (2) nurses to pronounce a resident dead. Additional interview revealed she told RN #1 she did not know, but she would check with another nurse. LPN #2 stated RN #1 told her no that's ok and then hung up the phone. Per interview, RN #1 did not say anything to her about Resident #1's code status. Continued interview with RN #1, revealed she then called the DON and was told to go do a code at which time RN #1 informed the DON, the resident was already dead. RN #1 stated the DON told her I don't care, call 911 and go do CPR. Per interview, RN #1 called 911, hung up the phone, and grabbed the code cart, but left it outside the resident's room. RN #1 stated she entered the resident's room, put on gloves, and pushed on the resident's chest about three (3) or four (4) times and stopped. RN #1 stated the resident was cold and she felt like it was wrong to continue with CPR because it had been about twenty (20) minutes since she initially found the resident unresponsive. Per interview, RN #1 stopped CPR, went to the nurse's station. RN #1 confirmed after she left the resident's room, nobody was performing CPR on the resident. Interview on [DATE] at 3:03 PM, with the DON, revealed she received a call from RN #1 on [DATE] at 6:07 PM, who stated Resident #1 had passed away. The DON revealed she directed RN #1 to check the resident's code status and when RN #1 identified the resident's code status was Full Code, she informed RN #1 she had to perform CPR. The DON revealed RN #1 told her it's too late, and she (DON) instructed RN #1 to perform CPR because Resident #1 was a Full Code and to call EMS. Per interview, RN #1 called back at 6:21 PM and informed her EMS had arrived and the resident was on the way to the Hospital emergency room . Additional interview with the DON, on [DATE] at 3:03 PM, revealed approximately one (1) hour later, LPN #1 called her and told her RN #1 had lied and reported LPN #1 performed CPR while RN #1 was making phone calls. The DON stated LPN #1 informed her she never touched the resident. Further interview revealed RN #1 should have checked the resident's code status, then immediately initiated CPR and continued CPR until EMS arrived and transported the resident to the hospital. Additional interview with LPN #1, on [DATE] at 12:15 PM, revealed at about 7:30 PM she overheard RN #1 talking to the triage center on the phone and overheard RN #1 state that LPN #1 was performing CPR to the resident while she (RN#1) was calling 911. However, LPN #1 stated that was not the truth, and she never layed hands on the resident. Continued interview revealed RN #1 should have checked Resident #1's chart for code status, and should have called a code blue when the resident was observed to be unresponsive with no respirations and heartbeat as per professional standards. Continued interview with RN #1, on [DATE] at 6:20 PM, revealed after she found the resident unresponsive with no respirations or heart rate, she should have checked the resident's code status, and immediately initiated CPR, and continued CPR until EMS arrived as per professional standards. However, she stated although she had worked codes in the hospital setting, she had only been working at the facility for two (2) months before the incident where she found Resident #1 unresponsive. She revealed she had not been oriented on how to initiate a code; how to use the crash cart; or how to complete code documentation after a code during orientation at the facility. RN #1 further stated she had asked both the Administrator who was a nurse, and the DON for the facility's protocol for conducting a code after hire. However, RN #1 stated she was informed by the DON, the SDC would get RN #1 the information whenever she had time. Review of RN #1's training submitted by the facility revealed there was no documented evidence the facility trained RN #1 on facility policies and procedure related to codes. Interview on [DATE] at 9:45 AM, with Staff Development Coordinator (SDC) #2, who no longer worked at the facility, revealed she had been employed by the facility for six (6) months and two (2) of those months she worked in the role of SDC. She revealed during her time at the facility as SDC, she was given a notebook by SDC #1 and told to go through the notebook with new hires. Per interview, she was not given any training on what her role or duties were as the SDC. Further interview revealed she was not given any orientation on hire on how to call a code, conduct a code, or how to use the crash cart and complete the code paperwork after a code. She stated the only thing related to codes she received in her three (3) day orientation, was a sheet of paper located in the orientation packet that went over the steps for CPR. She further stated nobody conducted mock code drills with new hires during orientation. Additional interview with SDC #2, revealed she oriented RN #1 and at that time, the orientation included information about the company, company policies, skills check offs including vital signs, weights, medication administration, how to care for gastrostomy-tubes and tracheotomies, and other nurse related tasks. However, SDC #2 revealed she did not recall covering information with new hires related to how to conduct a code or covering code status. SDC #2 stated the DON and Administrator just assumed if you were a nurse you knew how to conduct a code and perform CPR. SDC #2 stated if a resident was a Full Code she would expect any staff member who was CPR certified to perform CPR until EMS arrived and assumed care of the resident as per professional standards. Further interview with the DON, on [DATE] at 3:03 PM, revealed it was her expectation for all new licensed staff to receive training on the facility code policies and procedures, and RN #1 should have received this training during orientation. Continued interview with the DON, revealed she expected staff to follow the facility's CPR and Advance Directives Policy in order to ensure professional standards of care were met. Interview, on [DATE] at 11:40 AM, with Resident #1's Attending Physician (AP), revealed the facility did not inform him there was a delay in initiating CPR or that CPR had been initiated and stopped after only three (3) to four (4) chest compressions. Per interview, in the event a nurse found a resident unresponsive, he expected the nurse to follow the protocols outlined by the facility's policies, and per the American Heart Association's (AHA) recommendations, and initiate CPR. Additional interview revealed he expected CPR to be initiated in timely manner because the longer the delay, the less likely CPR would be successful. The AP revealed he expected the resident's choices to be honored in regards to Advance Directives and code status and expected the facility to follow professional standards of care. Interview on [DATE] at 3:33 PM, with the Administrator, revealed she was notified on [DATE] by the DON, Resident #1 had passed and there may have been a delay in initiation of CPR. She stated RN #1 failed to immediately verify the resident's code status by looking in Resident #1's chart and failed to initiate CPR in a timely manner. Also, she stated RN #1 failed to continue CPR until EMS arrived at the facility to assume care of the resident. Per interview, it was her expectation that staff follow facility's policy related to Advance Directives and CPR. Continued interview revealed it was her expectation licensed nurses receive orientation related to facility policies regarding CPR, and Advance Directives, and RN #1 should have received the training. The Administrator further stated Resident #1 had an Advance Directive for Full Code on admission, and professional standards of care should have been followed related to CPR and Advance Directives. Review of the A[NAME] revealed the facility implemented the following: 1. An investigation related to Resident #1 and the incident which occurred on [DATE], was initiated on [DATE] and completed by [DATE], by the Director of Nursing (DON) and the Administrator. During the investigation a review of Resident #1's medical record, code blue process, and cardiopulmonary resuscitation process, staff interviews, and resident interviews was completed. It was determined by the facility there was a failure in following policies and procedures including the

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F 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) Cardiopulmonary Resuscitation Policy and Care Plan Policy. 2. Beginning on [DATE] and concluding on [DATE], the DON, Assistant Director of Nursing (ADON), Unit Managers, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Coordinator, Restorative Nurse Manager and Nursing Supervisor received Mock Code training by the Registered Nurse Consultant (RNC). 3. Beginning on [DATE] and concluding on [DATE], all Registered Nurses (RN) and Licensed Practical Nurses (LPN) received Mock Code training by the SDC. RNs and LPNs received a post test and had to obtain a score of one hundred percent (100%). RNs and LPNs who had not completed the required training by [DATE] would be notified by certified letter, that they would not be allowed to work until the Mock Code training had been completed. As of [DATE], a total of twenty-two (22) out of twenty-seven (27) nurses completed training. Five (5) PRN (as needed) nurses the facility was unable to contact were sent certified letters stating they would not be scheduled to work until training was completed and that training was mandatory. The education related to the policies and procedures was added to the training agenda for New Employee Orientation. The facility does not utilize agency staff. 4. Education related to Advance Directive Policy and Procedure, where Advance Directives were located in the clinical record, Admission/Physician order [REDACTED]. Certified letters were sent to the thirteen (13) staff members to notify them of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers Nursing Supervisors or RNC. All licensed staff received a post test and were required to attain a passing score of one hundred percent (100%). The education related to the policies and procedures was added to the training agenda for New Employee Orientation. The facility does not utilize agency staff. 5. On [DATE], all Department Managers were educated by the RNC on the Advance Directive Policy and Procedure, Admission/physician's orders [REDACTED]. Department Managers could not return to work until education had been completed. 6. Beginning on [DATE] and concluding on [DATE], the Social Service Director, DON, Unit Managers, and Nursing Supervisors assessed all residents to ensure all quality of care needs were being met. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations. 7. Beginning on [DATE] and concluding on [DATE], compliance audits of the admission process were completed on all admissions within the previous thirty (30) days. The audits were performed by the DON, Unit Managers or RNC of all resident's medical records to ensure compliance with the admission process to include reviewing admitting orders including Advance Directives/code status, and care plans. 8. On [DATE], an audit was conducted of all licensed nurse personnel files for CPR certification and licensure by the Staff Development Coordinator (SDC). 9. Beginning on [DATE] and concluding on [DATE], audits of all residents who expired within the previous sixty (60) days were performed by the RNC to ensure: Advance Directives were signed and witnessed to designate code status; Code Status was designated by Advance Directive; physician's orders [REDACTED]. 10. By [DATE], an audit was conducted by the RNC on all Emergency Code Documentation sheets for the previous thirty (30) days for compliance with CPR Policy. 11. By [DATE], an audit was conducted by the RNC of all Accidents and Incidents for the previous thirty (30) days to ensure all code blue processes were followed and within compliance with the CPR Policy. 12. The DON, Unit Managers, SDC, MDS Coordinator, Restorative Nurse Manager, or Nursing Supervisor will conduct an audit/review of care plans daily to ensure accuracy with code status along with implementation and individualization of the care plan and the SRNA care plan. The findings will be reviewed by the DON daily during the morning clinical white board meeting and discussed with the QAPI team during monthly QAPI meeting. 13. The DON, Unit Managers, SDC, MDS Coordinator, Restorative Nurse Manager, or Nursing Supervisor will conduct an audit/review Nurse's Notes, Social Service Notes, Accidents and Incidents, and the Twenty-Four (24) Hour Report daily to ensure any change in condition noted had appropriate interventions implemented and updated on the care plan. The findings will be reviewed by the DON daily during the morning clinical white board meeting and discussed with the QAPI team during monthly QAPI meeting. 14. The DON, Unit Managers, SDC, MDS Coordinator, Restorative Nurse Manager, or Nursing Supervisor will conduct an audit/review of all emergency code documentation sheets daily to ensure completeness, accuracy, and compliance with CPR Policy and Procedure along with the process. The findings will be reviewed by the DON daily during the morning clinical white board meeting and discussed with the QAPI team during monthly QAPI meeting. 15. By [DATE], the Unit Managers, Nursing Supervisors, and the DON conducted an audit of all in house residents' charts regarding Advance Directives to ensure they were signed, witnessed, current, complete and matched code status; Code Status to ensure current, complete, displayed in chart and matched physician's orders [REDACTED]. 16. On [DATE], a Quality Assurance Performance Improvement (QAPI) Meeting was held to review the Immediate Jeopardy (IJ) incident, initiation of the investigation, and current plan for the Medical Directors input, recommendations, and approval. Additional QAPI meetings were held on [DATE] and [DATE] to review the on-going plan, compliance, validation, and for any needed recommended changes to the plan. Findings of the daily audits will be reviewed by the DON daily during clinical white board meetings and discussed with QAPI team during monthly QAPI. QAPI meetings will be conducted monthly for three (3) months to review the effectiveness of the plan with progression through the plan. The State Survey Agency validated the implementation of the facility's A[NAME] on [DATE] as follows: 1. Review of the facility's investigation of the incident involving Resident #1 on [DATE], revealed an audit of Resident #1's medical record was completed on [DATE] with areas of concern noted. Interview with the DON, on [DATE] at 3:03 PM, revealed she audited Resident #1's medical record and assisted with the investigation related to Resident #1, and identified areas of concern with CPR Policy and Procedure, Advance Directive Policy and Procedure, Professional Standards, and the Care Plan Policy not followed. Per interview, there was immediate implementation of education to licensed nursing staff. 2. Review of the (MONTH) (YEAR) calendar documentation of Mock codes, revealed all nursing administration staff had received Mock Code training by the RNC by [DATE]. Continued review revealed all licensed nursing staff had received Mock code training by [DATE] by the SDC. Interview on [DATE] at 3:03 PM with the DON; [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM with the SDC; [DATE] at 12:39 PM with the Reflections Unit Manager; [DATE] at 12:48 PM with the B Wing Unit Manager; and [DATE] at 2:38 PM with the A Wing Unit Manager; revealed they had received Mock code training in (MONTH) (YEAR) by the RNC. Interview on [DATE] at 12:54 PM with the RNC, revealed she had conducted Mock code training with all nursing administration staff. 3. Review of the (MONTH) calendar utilized to conduct mock code training for licensed nursing staff on 7:00 AM shift and 7:00 PM shifts, for two (2) weeks starting [DATE], revealed training had been conducted and reviewed by the DON for compliance weekly. Interview on [DATE] at 3:03 PM, with the DON, revealed mock code training for licensed staff on 7:00 AM shift and 7:00 PM shifts had been conducted for two (2) weeks starting [DATE] and reviewed by her for compliance weekly. Continued interview revealed the DON presented the audit findings to the monthly QAPI team meetings. Interviews on [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM with the SDC; [DATE] at 12:39 PM with the B Wing Unit Manager; [DATE] at 12:48 PM with the Reflections Unit Manager; [DATE] at 12:55 PM with the Restorative Nurse Manager; [DATE] at 1:18 PM with the MDS Coordinator; and [DATE] at 2:38 PM with the A Wing Unit Manager; revealed they had conducted mock code training for licensed staff on 7:00 AM shift and 7:00 PM shifts for two (2) weeks starting on [DATE]. Interview on [DATE] at 12:30 PM with LPN #1; [DATE] at 2:23 PM with LPN #8; [DATE] and at 3:05 PM with LPN #2; [DATE] at 12:55 PM with RN #4; [DATE] at 2:36 PM with RN #6; [DATE] at 4:25 PM with LPN #7; and [DATE] at 4:37 PM with LPN; revealed they had received Mock code training in (MONTH) (YEAR) by the SDC. 4. Review of the education provided to all licensed staff related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. Review of the POS [REDACTED]. Review of the New Hire Orientation Packet revealed the education related to the policies and procedures had been added to the training agenda for New Employee Orientation. Interview on [DATE] at 12:30 PM, with LPN #1; [DATE] at 2:23 PM with LPN #8; and [DATE] at 3:05 PM with LPN #2; revealed they had received education related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED].

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F 0658 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 6) Interview on [DATE] at 12:55 PM with RN #4; [DATE] at 2:36 PM with RN #6; [DATE] at at 4:25 PM with LPN #7; and [DATE] at 4:37 PM with LPN #8; revealed they had received education related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. 5. Review of the education provided to all Department Managers related to Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. Review of the POS [REDACTED]. Interview on [DATE] at 3:03 PM with the DON; [DATE] at 6:00 PM with the D Wing Unit Manager; [DATE] at 12:10 PM wi (TRUNCATED)
F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure staff provided immediate basic life support, including Cardiopulmonary Resuscitation (CPR) prior to the arrival of emergency medical personnel, as per physician's orders [REDACTED].#1). On [DATE], Resident #1 was admitted to the facility with an Advance Directive/Informed Consent Form, which stated, Full Code. On [DATE], per staff interview and record review, at approximately 5:45 PM, Registered Nurse (RN) #1 observed Resident #1 to be unresponsive and cold to the touch with absence of respirations and heartbeat. RN #1 was not knowledgeable of the facility's protocol when a resident was found unresponsive and called out to Licensed Practical Nurse (LPN) #1, who came to the resident's room. However, neither RN #1 or LPN #1 immediately checked the resident's code status. RN #1 then overhead paged for a nurse from other units to call Unit B Hall immediately. Staff interviews revealed RN #1 subsequently called the Director of Nursing (DON) at approximately 6:07 PM and the DON directed her to check the resident's chart for code status. After RN #1 identified the resident was a Full Code, 911 was called, and CPR was initiated at approximately 6:08 PM, approximately twenty-three (23) minutes after the resident was found with absence of respirations and heartbeat. RN #1 performed three (3) to five (5) chest compressions, and then stopped CPR. Review of the Emergency Medical Response Report revealed Emergency Medical Services (EMS) received a call on [DATE] at 6:08 PM and arrived on scene at 6:14 PM to find Resident #1 in [MEDICAL CONDITION] with no efforts at CPR or oxygenation. EMS transported Resident #1 to the Hospital where the resident was pronounced dead on [DATE] at 6:53 PM. The facility's failure to have an effective system in place to ensure staff provide immediate basic life support, including Cardiopulmonary Resuscitation (CPR) prior to the arrival of emergency medical personnel, as per physician's orders [REDACTED]. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on [DATE] and determined to exist on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. However, the State Survey Agency (SSA) determined the Immediate Jeopardy was not removed on [DATE] as alleged. Through record review, the SSA identified discrepancies regarding code status related to Advance Directives, physician's orders [REDACTED]. The facility made corrections and conducted another audit on [DATE]. Therefore, the SSA determined the Immediate Jeopardy was not removed until [DATE]. Non-compliance remains at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's Cardiopulmonary Resuscitation Policy, undated, revealed CPR would be attempted for any resident who was found to have no palpable pulse and/or no discernible respirations, unless there was a written physician's orders [REDACTED]. Continued review revealed if a resident was found unresponsive and without respirations, a licensed staff member who was certified in CPR would promptly initiate CPR for residents who had requested CPR in their Advance Directive; for residents who had not formulated an Advance Directive; and for residents who did not have a valid DNR order; or unless it would pose a danger to self or others to initiate CPR. Further review revealed CPR would be continued by the facility staff until EMS arrived to assume responsibility for providing CPR. Review of the facility's Advance Directives Procedure Policy, revised on [DATE], revealed upon admission to the facility, the admitting department would inform the resident that he/she had the right to accept or refuse medical treatment and the right to formulate an Advance Directive. Continued review revealed if the resident or resident's representative stated the resident had completed an Advance Directive, it should be documented in the resident's medical record. Review of Resident #1's medical record revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Advance Directive/Informed Consent Form, signed by the resident's son on [DATE], revealed Full Code, indicating in the event the resident experienced a cardiopulmonary arrest, the resident wanted Cardiopulmonary Resuscitation (CPR) performed. Review of Resident #1's physician's orders [REDACTED]. Review of the resident's Baseline Care Plan, dated [DATE], revealed the resident and family had elected Full Code. Review of Resident #1's Progress Note, dated [DATE] at 6:28 PM, signed by RN #1, revealed RN #1 entered the resident's room to pick up the dinner tray, and the resident was noted to be unconscious and did not respond to word or touch. Per the Note, Resident #1's skin was cold and his/her eyes were open. Further review of the Note, revealed RN #1 placed the resident in a lying position and started CPR; and LPN #1 quickly replaced RN #1 in order for RN #1 to call 911 and the family. Per the Note, CPR continued and EMS arrived and took over life resuscitation attempts. Review of the facility's Investigation Report, completed by the Administrator, dated [DATE], revealed Resident #1 was given his/her dinner tray at approximately 5:15 PM on [DATE] by RN #1. RN #1 returned to the resident's room at approximately 5:45 PM and found Resident #1 cold, with his/her eyes open, unresponsive, and CPR was initiated. EMS was called and the resident was transported to the hospital where he/she later expired. Continued review of the Investigation Report, revealed an interview was conducted with RN #1 who revealed she initiated CPR to Resident #1 after speaking with the DON by phone, and being instructed to do so. Further review revealed RN #1 stated she initiated CPR, but became confused and called the resident's son to inform him of the resident's condition. Per the Report, while RN #1 was on the phone with the resident's son, EMS arrived and took over CPR and transported the resident to the hospital. There was no timeline of events with the investigation. Review of RN #1's written Statement, undated, revealed she was picking up dinner trays around 5:45 PM, when she walked into Resident #1's room and noted the resident's head to be slightly turned with his/her eyes and mouth open, and the resident's skin looked yellow and waxy; she touched the resident's arm which was cold. The Statement revealed she realized something was wrong so she felt the resident's neck for a pulse and there was none. Per the Statement, RN #1 looked at the resident's dinner tray and saw the resident had only taken three (3) bites out of his/her hamburger. RN #1 did a sweep of the resident's mouth and did not find any food. The Statement revealed RN #1 did not have her stethoscope with her so she put her head on the resident's chest and heard no breathing so she went out into the hall and called for LPN #1 who came to the resident's room and examined the resident. LPN #1 asked RN #1 if the resident was a Full Code at which time RN #1 asked LPN#1 to stay with the resident so she could call the DON and ask her what needed to be done. The Statement revealed while RN #1 was walking to the phone to call the DON, she passed SRNA #1 and SRNA #2 and asked them to go and clean the resident for the funeral home. Further review of RN #1's Statement, revealed she called the DON and informed her Resident #1 had passed and the DON asked if the resident was a Do Not Resuscitate (DNR). RN #1 looked at the resident's chart and saw Full Code and the DON instructed her to call a code and start CPR. Per RN #1's statement, she hung up the phone, got the crash cart, and took it to the resident's room where the SRNAs were cleaning the resident up. She donned gloves, walked over to the resident, and started to do CPR, and as she was performing chest compressions, she (RN #1) suddenly choked and didn't know what to do. Per the Statement, she knew the DON told her to do CPR, but the DON had not seen the resident in this condition and she (RN#1) felt it was too late. The Statement revealed the SRNAs were watching her and she felt it was disrespecting the resident by performing CPR when the resident was already too far gone. Per the Statement, RN #1 felt she needed to call the resident's son so she left the room and honestly did not know what to do next. Continued review of the Statement, revealed RN #1 went back to the desk and called for another nurse on another unit and then called the resident's son and broke the news. She told the son that she was going to do CPR, but felt it was too late and the son stated he understood and was glad the resident did not suffer. Per the Statement, while on the phone with the

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) son, EMS arrived and came to the nurse's station and RN #1 informed the son she needed to get off the phone because EMS was there to take the resident to the hospital. The Statement revealed RN #1 followed EMS to the resident's room and EMS saw the Full Code on the chart and proceeded to start CPR. RN #1 worried for a moment she might be wrong and the resident had not died , and as she (RN#1) stood back and watched EMS, she didn't really know what to do. Additional review of the Statement, revealed RN #1 thought the resident might recover so she left the room and went to call the son back to inform him EMS was taking the resident to the hospital and the hospital could help the son with any arrangements that needed to be made. Interview on [DATE] at 6:20 PM with RN #1, revealed she was the nurse assigned to Resident #1 on [DATE], and at approximately 5:15 PM on that date, Resident #1 was in bed when she walked in the resident's room to deliver his/her dinner meal tray. RN #1 stated after the meal trays had been passed to other residents, she began to pick-up meal trays for those residents who were finished eating. She stated she entered Resident #1's room at approximately 5:45 PM to pick up the resident's dinner tray and noticed his/her eyes were slightly open. Per interview, she reached down and touched the resident who was cold to the touch. She did not have her stethoscope with her, so she put her head on the resident's chest to see if he/she was breathing. RN #1 stated the resident was not breathing, so she checked his/her mouth because she saw there was about three (3) bites missing out of the hamburger on the meal tray. RN #1 further stated she did not find anything in the resident's mouth, and she then checked the resident's pulse and noted there was no pulse. Per interview, RN #1 went to the door and yelled down the hall for LPN #1, who came to the room. RN #1 stated she told LPN #1 she thought the resident had passed away and asked LPN #1 what she should do. Per interview, LPN #1 told her she needed to call the DON, and she and LPN #1 then headed to the nurse's desk because neither one of them knew the facility's protocol for finding a resident unresponsive. Further interview with RN #1, revealed she and LPN #1 passed SRNA #1 and SRNA #2 in the hall on the way to the nurse's station and told them Resident #1 had passed away and asked them to go to the resident's room and make him/her presentable. RN #1 stated she went to the nurse's station and called Unit A and Unit D to find out what the protocol was for finding a resident unresponsive and no one answered the phone so she overhead paged for a nurse from Unit A or Unit D to call Unit B Hall immediately. Per interview, LPN #2 returned the call and asked RN #1 about the resident's code status. RN #1 stated she was looking in the chart and saw a sticker that said Full Code, then informed LPN #2 the resident was a Full Code. Per interview, LPN #2 told RN #1 you are supposed to code {him/her}. Interview on [DATE] at 3:05 PM with LPN #2, who worked the 7:00 AM to 7:00 PM shift as needed at the facility, and was working the evening of [DATE] on A Wing Rehab Unit passing medications when she heard an overhead page for an RN or LPN to call B Wing immediately. LPN #2 stated she responded to the page, and RN #1 answered the phone. LPN #2 further stated RN #1 asked her of it took two (2) nurses to pronounce a resident dead. Further interview revealed she told RN #1 she did not know, but she would check with another nurse. LPN #2 stated RN #1 told her no that's ok and hung up the phone. LPN #2 further stated RN #1 never said anything to her about Resident #1's code status. Per interview, later that night, she heard RN #1 did not perform CPR on a resident that was a Full Code. Additional interview with RN #1, on [DATE] at 6:20 PM, revealed she was in a panic mode and called the DON and was told to go do a code at which time RN #1 informed the DON, the resident was already dead. RN #1 stated the DON said I don't care, call 911 and go do CPR. RN #1 further stated she called 911, hung up the phone, and grabbed the code cart, but she left it outside the resident's room. Per interview, when RN #1 walked into the resident's room, SRNA #1 and SRNA #2 had the resident lying flat in the bed and were cleaning the resident. RN #1 stated she put on gloves and told the SRNAs the DON told her to do CPR on the resident. RN #1 further stated she pushed on the resident's chest about three (3) or four (4) times and stopped. Continued interview with RN #1, revealed the resident was cold and she felt like it was wrong to continue with CPR because it had been about twenty (20) minutes since she found the resident unresponsive. RN #1 stated she stopped CPR, went to the nurse's station, and called the resident's son to inform him she thought the resident had passed away. Continued interview with RN #1, revealed after she left the resident's room, nobody was performing CPR on the resident. Further interview with RN #1, revealed once she initiated CPR, she should have continued CPR until EMS arrived. Review of LPN #1's written Statement, dated [DATE], revealed on Sunday, [DATE] at approximately 5:30 PM, RN #1 asked LPN #1 to go check Resident #1 because RN #1 wanted LPN #1 to verify the resident had passed away. Per the Statement, LPN #1 went to the resident's room and the resident was in an upright position, the resident's arms were limp to his/her side, and his/her eyes were closed. The resident was not breathing because the resident's chest was not moving and the resident was cold to the touch. Per LPN #1's Statement, RN #1 told her to get the SRNA to clean the resident. Additional review of the Statement, revealed at approximately 6:30 PM, she saw RN #1 at the nurse's station and RN #1 reported to LPN #1 she had started CPR, called 911, called the family, and called the DON. Per LPN #1's Statement, at approximately 7:30 PM, she was at the nurse's station and overheard RN #1 speaking to the triage call center. The Statement revealed LPN #1 heard RN #1 state that LPN #1 had performed CPR on the resident while RN #1 called 911. Per the Statement, that was not true and she (LPN #1) reported what she had seen and heard to the C Wing Unit Manager. Interview on [DATE] at 12:15 PM, with LPN #1, revealed she was passing medications on B Wing South Hall on [DATE] at approximately 5:30 PM, when RN #1 called out to her. She stated RN #1 told her a resident had died and she wanted her to check the resident. LPN #1 stated she entered Resident #1's room and observed the resident sitting up in the bed with eyes slightly open, and chest not moving. LPN #1 further stated she touched the resident's hand which was cold. Per interview, neither she or RN #1 checked to see if Resident #1 had a pulse or respirations. LPN #1 stated she and RN #1 left the room to go to the nurse's station to call the DON. Per interview, no one was performing CPR on the resident at this time. LPN #1 stated as she and RN #1 were walking to the nurse's station they passed SRNA #1 and SRNA #2 in the hall and RN #1 instructed the SRNAs to clean the resident. Further interview with LPN #1, revealed she went back to her unit to finish passing medications while RN #1 called the DON. Per interview, at around 7:30 PM she overheard RN #1 talking to the triage center on the phone and overheard RN #1 state that LPN #1 was performing CPR to the resident while she (RN#1) was calling 911. LPN #1 stated that was not the truth, and she never layed hands on the resident. LPN #1 further stated she and RN #1 should have checked Resident #1's chart for code status, and should have called a code blue when the resident was observed to be unresponsive. Per interview, RN #1 should have grabbed the crash cart and started CPR on the resident immediately and continued CPR until EMS arrived. Review of the C Wing Unit Manager's written Statement, dated [DATE], revealed LPN #1 approached her and informed her she did not help RN #1 start CPR on Resident #1. Review of State Registered Nurse Aide (SRNA) #1's Statement, dated [DATE], revealed a nurse told SRNA #1 and SRNA #2 to go clean up Resident #1 because he/she had passed. The Statement further revealed while SRNA #1 and SRNA #2 were cleaning the resident, RN #1 came into the resident's room and stated the resident was a Full Code and she had called the ambulance, but was not going to waste the crash cart. Per SRNA #1's Statement, RN #1 left the room and called the resident's family. The Statement further revealed the ambulance arrived and SRNA #1 left the room. Interview on [DATE] at 4:10 PM, with SRNA #1, revealed on [DATE], sometime between 5:45 PM and 6:15 PM, she heard someone page we need an RN on B wing. Per interview, not long after that, LPN #1 came up to her and said, go clean up Resident #1 because the resident just passed. SRNA #1 stated after she and SRNA #2 cleaned the resident and was changing the resident's gown, RN #1 came into the room and told them the resident was a Full Code. SRNA #1 stated she expected to see RN #1 perform CPR on the resident, but instead RN #1 just did three (3) taps on the resident's chest and told them the resident was not going to come back, he/she was eighty (80) years old, and was hospice. Further interview revealed RN #1 told them, I'm not going to waste my crash cart. SRNA #1 stated RN #1 then left the resident's room, and a few minutes later, while she and SRNA #2 were still in the resident's room, EMS arrived. Continued interview with SRNA #1, revealed Resident #1 wasn't cold when she and SRNA #2 were cleaning the resident. SRNA #1 stated RN #1 should have brought the crash cart into the resident's room and performed CPR until EMS arrived since the resident was a Full Code. Per interview, staff did not perform CPR on Resident #1 after RN #1 left the room, and she left the room after EMS arrived. Review of SRNA #2's Statement, dated [DATE], revealed at supper time RN #1 approached SRNA #2 and SRNA #1, and told them Resident #1 had passed and needed to be cleaned up. Per SRNA #2's Statement, she and SRNA #1 were cleaning the resident when RN #1 walked into the room and said Resident #1 was a Full Code, but she didn't see the resident coming back. Per the Statement, RN #1 brought the crash cart down the hall, but didn't call a code. SRNA #2's Statement revealed RN #1 stated she wasn't going to waste the crash cart. SRNA #2's Statement further revealed RN #1 did five (5) chest compressions and said the resident was not coming back and walked out of the resident's room, went to the nurse's station, and got on the

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) phone. Per SRNA #2's Statement, when the ambulance arrived she left the resident's room. Interview on [DATE] at 4:04 PM, with SRNA #2, who was assigned to Resident #1 on [DATE], revealed on that date between 6:10 PM and 6:15 PM, LPN #1 informed her Resident #1 had passed and needed to be cleaned. SRNA #2 stated she went to get linens and when she passed the nurse's station she saw RN #1 at the desk talking on the phone. SRNA #2 stated while she and SRNA #1 were cleaning the resident, RN #1 came in the resident's room and told them the resident was a Full Code and she needed to perform CPR. Per interview, RN #1 left the crash cart in the hall outside the resident's room, performed about five (5) chest compressions, stopped CPR, left the room, and stated she didn't want to waste the crash cart on the resident because she didn't see the resident coming back. SRNA #2 stated she and SRNA #1 stayed in the resident's room and were gathering up the resident's belongings for the family when EMS arrived and took the resident to the hospital. Further interview revealed Resident #1 wasn't cold when she and SRNA #1 were cleaning the resident. SRNA #2 stated RN #1 should have brought the crash cart into the resident's room and performed CPR until the ambulance arrived. SRNA #2 verified staff did not perform CPR on Resident #1 after RN #1 left the room, and she (SRNA #2) left the room after EMS arrived. Review of the DON's Statement, dated [DATE], revealed RN #1 called her at 6:07 PM and stated Resident #1 had passed away. The DON asked RN #1 if Resident #1 was still in the facility and RN #1 stated yes. Continued review of the Statement, revealed the DON instructed RN #1 to get off the phone and perform CPR immediately, call a code blue, and call 911 because the resident was a Full Code, at which time RN #1 stated it was too late. Per the DON's Statement, she told RN #1 she didn't care if RN #1 thought it was too late, she needed to begin CPR now. Further review of the Statement, revealed RN #1 called the DON back at 6:21 PM, stating EMS had arrived, hooked the resident up to the compression machine, and took the resident out of the facility. Per the Statement, the DON asked RN #1 if she performed CPR and RN #1 stated she did. Interview on [DATE] at 3:03 PM, with the DON, revealed she received a call from RN #1 on [DATE] at 6:07 PM, stating Resident #1 had passed away. The DON stated she directed RN #1 to check the resident's code status. Per interview, when RN #1 identified the resident's code status was Full Code, she informed RN #1 she had to perform CPR. The DON stated RN #1 told her it's too late, and she (DON) instructed RN #1 to perform CPR because Resident #1 was a Full Code and to call EMS. The DON further stated, RN #1 called back at 6:21 PM and informed her EMS had arrived and the resident was on the way to the Hospital emergency room (ER). Continued interview with the DON, revealed approximately six (6) to seven (7) minutes later, SRNA #2 called and stated I've never seen a nurse start CPR and not keep going. The DON further stated SRNA #2 informed her RN #1 only did four (4) to five (5) chest compressions and stopped. Further interview revealed approximately one (1) hour later, LPN #1 called her and told her RN #1 had lied and reported LPN #1 performed CPR while RN #1 was making phone calls. Per interview, LPN #1 informed the DON she never touched the resident. Additional interview revealed RN #1 should have checked the resident's code status, then immediately initiated CPR and continued CPR until EMS arrived and transported the resident to the hospital. Review of Resident #1's Emergency Medical Response Report, dated [DATE], revealed EMS received a call on [DATE] at 6:08 PM and arrived on scene at 6:14 PM to find Resident #1 in [MEDICAL CONDITION]. The Report revealed the resident was in arrest for an unknown amount of time with no efforts at CPR or oxygenation and the resident was unresponsive, warm to touch, and no lividity was noted. Further review of the Report, revealed on EMS arrival, the nurse was at the nurse's station with no efforts being made for CPR, no one was with the resident, and the resident appeared to have been dressed and posed. The Report further stated a right [MEDICAL CONDITION] tracheal tube and intraosseous line was placed, [MEDICATION NAME] (medication used as a heart stimulant), [MEDICATION NAME] (medication to relax muscles), and [MEDICATION NAME] (opioid antagonist) was given enroute and the Lucas Device was used for compressions. Per the report, EMS departed the scene at 6:34 PM and CPR was discontinued at 6:55 PM. Review of Resident #1's Hospital emergency room documentation, dated [DATE], revealed Resident #1 arrived at the hospital on [DATE] at 6:42 PM, unresponsive with [DIAGNOSES REDACTED]. Further review revealed upon arrival to the Emergency Department, Resident #1 was administered intravenous (IV) fluids at 6:41 PM, [MEDICATION NAME] one (1) milligram (mg) IV at 6:42 PM, at 6:45 PM, at 6:48 PM and at 6:51 PM with no change in condition. Continued review revealed time of death was 6:53 PM. Interview, on [DATE] at 11:40 AM, with Resident #1's Attending Physician (AP), revealed he was informed on [DATE] Resident #1 had expired. Per interview, he was aware the resident had been admitted to the facility on [DATE] with a Full Code status, but was not aware there was a delay in initiating CPR and was not aware CPR had been initiated and stopped after only three (3) to four (4) chest compressions. Continued interview with the AP, revealed in the event a nurse found a resident unresponsive, he expected the nurse to follow the protocols outlined by the facility's policies, and per the American Heart Association's (AHA) recommendations, and initiate CPR. Further interview revealed he expected CPR to be initiated in timely manner because the longer the delay, the less likely CPR would be successful. Per interview, he expected the resident's choices to be honored in regards to Advance Directives and code status. Continued interview with RN #1, on [DATE] at 6:20 PM, revealed she had been a nurse for fifteen (15) years and had worked codes in the hospital setting, but had only been working at the facility for two (2) months before the incident where she found Resident #1 unresponsive. She stated she had not been oriented related to how to initiate a code; how to use the crash cart; or how to complete code documentation after a code during orientation at the facility. RN#1 stated she had asked both the Administrator who was a nurse, and the DON for the facility's protocol for conducting a code after hire. However, RN #1 stated she was told by the DON, the Staff Development Coordinator (SDC) would get RN #1 the information whenever she had time. Per interview with RN #1, she could not remember the date in which she had asked the Administrator or the DON for the training on how to conduct a code. Review of RN #1's training submitted by the facility revealed there was no documented evidence the facility trained RN #1 on the facility policies and procedure related to codes. Review of RN #1's Basic Life Support Card, revealed it was issued ,[DATE] verifying successful completion of the cognitive and skills evaluation in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program. Interview on [DATE] at 7:35 PM, with Staff Development Coordinator (SDC) #1, revealed she was responsible for providing orientation to new staff and conducting in-services and education to all staff. The SDC stated new licensed nursing staff had three (3) to four (4) days of classroom orientation which covered information about the company and its policies. She stated new licensed nursing staff watched videos on hand washing, infection control, falls, wounds, weights, and there was also a skills check off prior to staff working the floor. Per interview, during orientation she went over the CPR policy, where the crash cart was located and the contents of the cart. Continued interview revealed mock code drills were conducted once a month, but she did not conduct a mock code during new hire orientation. The SDC stated during orientation staff watched a slide presentation which included how to announce a code; how to run a code; and where to find code paperwork and complete the code paperwork. Per interview, she did not provide new hire orientation to RN #1. However, she stated all nurse's in the facility were required to be CPR certified and RN #1 should have known how to conduct a code and perform CPR. Further interview revealed once CPR was started, it should not be stopped until EMS arrived and assumed care of the resident. Interview on [DATE] at 9:45 AM with SDC #2, who no longer worked at the facility, revealed she had been employed by the facility for six (6) months and two (2) of those months she worked as the SDC. She stated during her time at the facility as SDC, she was given a notebook by SDC #1 and told to go through the notebook with new hires. Per interview, she was not given any training on what her role or duties were as SDC. Continued interview revealed she was not given any orientation on hire on how to call a code, conduct a code, or how to use the crash cart and complete the code paperwork after a code. Per interview, the only thing related to codes she received in her three (3) day orientation, was a sheet of paper located in the orientation packet that went over the steps for CPR. Further interview revealed no one conducted mock code drills with new hires during orientation. Additional interview with SDC #2, revealed she remembered she had oriented RN #1 and at that time, the orientation included information about the company, company policies, skills check offs including vital signs, weights, medication administration, how to care for gastrostomy-tubes and tracheotomies, and other nurse related tasks. Per interview, SDC #2 did not recall covering information with new hires related to how to conduct a code or covering code status. SDC #2 stated the DON and Administrator just assumed that if you were a nurse you knew how to conduct a code and perform CPR. Ongoing interview with SDC #2, revealed if a resident was a Full Code she would expect any staff member who was CPR certified to perform CPR until EMS arrived and assumed care of the resident. Per interview, resident's Advance Directives should be honored.

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) Continued interview with the DON, [DATE] at 3:03 PM, revealed she expected staff to follow the facility's CPR and Advance Directives Policy. Per interview, she expected all new licensed staff to receive training on where to find code status in the chart, how to use the crash cart, how to call a code, and how to complete code paperwork during orientation by the SDC. She further stated RN #1 should have received this training during orientation. Interview on [DATE] at 3:33 PM, with the Administrator, revealed she was notified on [DATE] by the DON, Resident #1 had passed and there may have been a delay in CPR. Per interview, RN #1 failed to immediately verify the resident's code status by looking in Resident #1's chart and failed to initiate CPR in a timely manner. In addition, she stated RN #1 failed to continue CPR until EMS arrived at the facility to assume care of the resident. She stated it was her expectation that staff follow facility's policy related to Advance Directives and CPR. The Administrator further stated Resident #1 had an Advance Directive for Full Code on admission, and the resident's wishes should have been honored by the facility and the staff. Further interview revealed it was her expectation licensed nurses received orientation related to facility policies regarding CPR, and Advance Directives, and RN #1 should have received the training. Review of the A[NAME] revealed the facility implemented the following: 1. An investigation related to Resident #1 and the incident which occurred on [DATE], was initiated on [DATE] and completed by [DATE], by the Director of Nursing (DON) and