STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675932	A. BUILDING _____ B. WING _____	08/06/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR TERRACE HEALTHCARE CENTER	609 RIO CONCHO DR SAN ANGELO, TX 76903

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident was free from neglect for 1 of 3 residents reviewed for neglect (Resident #1). The facility did not initiate CPR for Resident #1 when he was found unresponsive, with no respirations and no pulse. Resident #1 was a full code. Resident #1 was pronounced dead in the facility by RN A on [DATE] at 8:17 AM. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at a level of actual harm with a scope identified as isolated due to the facility's need to complete training of all staff and monitor the plan of removal. This failure affected one resident who died on [DATE] and could place 49 residents who were documented as requesting full code status at risk of not being provided resuscitation, which could lead to death. Findings include: Review of Resident #1's undated Face Sheet indicated he was [AGE] years old and was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #1's MDS assessment dated [DATE] indicated he had moderate cognitive impairment. He was occasionally incontinent of urine and frequently incontinent of bowel. He required limited assistance of one person for ADLs. Review of Resident #1's Physician order [REDACTED].>Review of Resident #1's Baseline Care Plan dated [DATE] indicated his goal was to discharge to the community. Review of a nurse's note dated [DATE] at 10:59 A.M., by RN A, included the following: Skilled nursing svcs (services), DX: acute kidney failure, diabetes, [MEDICAL CONDITION]. @ 06:15 went to Room B7 to check blood sugar level. The blood sugar was 157 and 6 units Humalog were given to abdomen. Resident was conversant and remained lying down during entire procedure. I left the room and continued on with my blood sugar checks. At 8:15 the aides were summoning me to B7 because Resident appeared to have passed. I assessed with [REDACTED]. I determined deceased at 8:17. I notified resident physician and family at 8:30 and notified staff of the deceased . Review of nurse's note dated [DATE] at 15:10 (3:10 PM), by RN A, included the following: Addendum to [DATE]; 10:59 AM entry. When I was assessing resident (#1) for signs of life I noted that the resident was unresponsive with cold fingers. His face was very blue. Eyes were fixated with no response to light. I listened with stethoscope to all lung and heart regions with no response. I checked for pulses in the carotid arteries as well as brachial pulses. No pulses and no respiration. Exterior distal extremities were cold to touch and very pale. I noted cyanosis in the abdominal region. Resident was lying on the left side with face turned to left. There were no emissions of bodily fluids from mouth or bowels. No odor was present. The left side was darkened by blood pooling. Review of the Provider Investigation Report dated [DATE] included the following Investigation Summary: The Administrator conducted the investigation through review of the Texas Board of Nursing statements/statutes, medical records and staff interviews. At 0615 on [DATE] (RN A) entered (Resident #1's) room to conduct a blood sugar check and administer insulin prior to his meal. (Resident #1) was awake and responsive to (RN A's) conversation. Between 0715 and 0730, (CNA B) took (Resident #1) his breakfast tray and appeared to be sleeping. (Resident #1 did not respond to (CNA B's) good morning. At between 0800 - 0815, (CNA B) went back to pick up the tray and (Resident #1) had not touched his food. (CNA B) attempted to arouse (Resident #1) and got no response. At that point, (CNA B) felt for a pulse and did not feel one. She caught another CNA in the hallway and had them go get (RN A). At 0815 (RN A) came into the room and attempted to arouse (Resident #1). He was still unresponsive so (RN A) performed a sternum rub and (Resident #1) was still unresponsive. (RN A) then assessed (Resident #1) for pulse, respirations and eye dilitations (sp). None were present. (RN A) noted (Resident #1's) face was blue and extremities were cold to the touch. (RN A) pronounced his death at 0817 and notified the attending physician and family around 0830. The Administrator finds this unconfirmed for neglect due to the RN [MEDICATION NAME] within his scope of practice according to the TBON. In an interview on [DATE] at 9:40 AM with the DON, she said the corporation added the BON statement on the RN Role in Withholding CPR . after the incident. (the previous Medical Director) signed it on [DATE]. We can follow the BON, we just added it to the policy to make it clear . In an interview with RN A on [DATE] at 10:10 AM he said he checked Resident #1's blood sugar at 6:10 AM, with a result of 157. He gave the resident 6 units of Humalog insulin (5 units ordered 3 times daily and 1 unit per sliding scale for blood sugar of 150 - 175). RN A said Resident #1 kind of came awake while he was checking his blood sugar and administering insulin. Afterwards, RN A said he went to the next hall to continue his rounds with other residents. RN A said that approximately 8:15 AM CNA B came to get him to come to Resident #1's room. He said the resident's face was blue, there was pooling in his abdomen, he was laying on his left side and the left side of his abdomen was kind of purplish. He said his eyes were glassy and his fingers were cold. He had no pulse or respirations. He said there was evidence of cyanosis, his face was real blue. RN A was unable to describe Resident #1's extremities looked like. He said, I didn't take his clothes off. RN A said he wrote the addendum nurse's note after he talked to the facility administrator and was told he needed more documentation, nothing specific, just more complete documentation. In an interview with the facility administrator he said they had a conference call with the RNC after Resident #1 death. He said the RNC had questions that were not in RN A's original nurse's note. He said he had RN A do the addendum to include the information he told us on the conference call. In a telephone interview with CNA B on [DATE] at 10:30 AM she said the day Resident #1 died was her second day of orientation. She said that she and the other CNAs were passing out breakfast trays on the halls. She said she was told that Resident #1 would eat when he wakes up, and to just leave his tray for him. She said when she came back after breakfast, she told him she was going to take his tray, and he didn't respond. She said he was lying on his back and she noticed his hands were cold. She checked for a pulse and saw he wasn't breathing. She said she didn't notice any skin discoloration, he looked the same to her. She said CNA D was picking up trays across the hall and she called her to Resident #1's room. She walked in and asked if he was okay, then went to get a nurse. LVN C came to the room and told CNA B to go get RN A. In a telephone interview with LVN C on [DATE] at 10:43 AM she said One of the girls down the hall said they needed help. RN A was down another hall. I called out to him and we went to Resident #1's room. He was unresponsive. RN A shook his arm. He wasn't breathing. He was on his back with a pillow under his head. His tray was there, and it looked like he had eaten and gone back to sleep. The cover was off the tray with food eaten. LVN C said she had never seen Resident #1 before as she works other halls. LVN C could not describe the appearance of Resident #1's face.

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) In a telephone interview with CNA D on [DATE] at 11:15 AM she works part time. On the day Resident #1 died she said she worked 8:00 AM - 2:00 PM. She said they (the CNA's) were picking up breakfast trays. Resident #1's room was on the right side of the hall and she was picking up trays on the left side of the hall. CNA B came out of his room and told me to get a nurse. I got (LVN C) from the rotunda. She came and checked Resident #1 and said to go get RN A. He came and checked (the resident). Me and (CNA B) left with his tray. She said nothing on his breakfast tray was touched. She said he would usually sit in the recliner for his meals. When I checked his pulse, he was cold. I turned off the air conditioner. He was down in the bed. He looked like he was asleep with lots of blankets and the AC on cold. That's how he liked it. He was uncovered to the chest and his left arm was out. He was on his back. His skin on his arm was kind of purple red. His face was flushed, his cheeks purplish red. His mouth was open, and his eyes were closed with tears puddled in the corners. RN A was in a lot of shock. We (the CNAs) left the room and LVN C was behind us I think. She said that neither of the nurses told them to call 911. In an interview with RN A on [DATE] at 11:57 AM he said he knew that Resident #1 was a full code when he was found unresponsive. He said he decided not to do CPR because it had been too long. He said Resident #1 had a 4-inch diameter area of pooling on his left abdomen. He said he did not turn the resident to further assess for lividity. In a telephone interview with RN A on [DATE] at 3:44 PM he said he did not initiate CPR for Resident #1 because too much time had passed, he hadn't touched his breakfast. He said he did not know specifically what the facility policy was at the time regarding CPR. He said there was an in-service the following day or so regarding what to do when a resident is found unresponsive: Call 911 and get the firemen; start CPR; let the paramedics make the call. He said he thought the facility had held mock codes in the past, but he had not attended. He said, All of us were supposed to have CPR certification. Review of licensed nursing staff personnel files revealed 14 out of 20 nurses, including the DON, did not have current CPR certifications at the time of Resident #1's death. RN A's CPR certification expired (MONTH) (YEAR). LVN C's CPR certification was current, expiring (MONTH) 2019. In an interview with RN A on [DATE] at 11:10 AM, (with the DON in attendance at RN A's request) in Resident #1's previous room, RN A demonstrated how the resident was lying on the bed and described the events of the morning of [DATE]: The bed was against the wall with the right side of the bed next to the window AC unit. RN A said that Resident #1 was usually groggy in the mornings. He said a CNA delivered his breakfast at approximately 7:30 AM. He said that he was on C hall at approximately 8:15 AM when CNA B came to get him to go to Resident #1's room. The resident was lying on his left side. His face was very blue. RN A said he went to the nurses' desk to get his stethoscope. When he returned he did a sternal rub on Resident #1 without response. He checked the resident's eyes with a penlight and there was no pupil reaction. He said the felt the resident's fingers and they were cold. He said he was covered from waist down with blankets. He had a shirt on. He said there was an approximately 4-inch circumference discoloration on his left abdomen. He said that after his assessment of the resident he returned to the nurses' station and called the resident's doctor and his family regarding his death. He then told the Interim DON and the ADON. The Administrator, DON and RNC were notified of the Immediate Jeopardy situation on [DATE] at 3:55 PM. In a telephone interview on [DATE] at 11:10 AM with the facility Medical Director who was also Resident #1's primary physician, he said he did not remember exactly what RN A had said when he called him and reported Resident #1's death at the facility, as he did not have immediate access to his records. He was notified of the Immediate Jeopardy situation. He said that for a resident who was a full code he would expect the nursing staff to start CPR and call 911. He said he was not aware until now of the circumstances of Resident#1's death. Review of the facility's Code Status System, revised [DATE], included the following, in part: Green alerts (located in the front of the clinical record) indicate the resident's desire to have CPR and every attempt to provide all heroic measures must be recognized. Review of www.bon.texas.gov/practice_wposition_statements_content.asp#15.20 accessed [DATE], include the following, in part: approved by the Board of Nursing (MONTH) 24, 2002, and last revised ,[DATE], included the following, in part: 15.20 Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility The Texas Board of Nursing (BON) has approved this position statement, only applicable to long term care settings, in an effort to provide guidance to registered nurse in long-term care facilities and to clarify issues of [MEDICATION NAME] end-of-life care . Assessment of death in which CPR would be a futile and inappropriate intervention requires that all seven of the following signs be present and that the arrest is unwitnessed: Presumptive Signs of Death 1. The resident is unresponsive; 2. The resident has no respirations; 3. The resident has no pulse; 4. Resident's pupils are fixed and dilated; 5. The resident's body temperature indicates hypothermia: skin is cold relative to the resident's baseline skin temperature; 6. The resident has generalized cyanosis; and Conclusive Sign of Death 7. There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin). RN Role in Withholding CPR With an Unwitnessed Arrest Pronouncement of Death There may be a time when initiating CPR is not [MEDICATION NAME] or is futile. The Texas Board of Nursing has provided the following position statement for an unwitnessed arrest AND pronouncing death: Unwitnessed Arrest In the case of an unwitnessed resident arrest without DNR orders, determination of the appropriateness of CPR initiation should be undertaken by the registered nurse through a resident assessment, and interventions appropriate to the findings initiated. Assessment of death in which CPR would be a futile and inappropriate intervention requires that all seven of the following signs be present and that the arrest is unwitnessed. Presumptive Signs of Death 8. The resident is unresponsive, 9. The resident has no respirations, 10. The resident has no pulse, a. Resident's pupils are fixed and dilated. 11. The resident's body temperature indicates hypothermia: skin is cold relative to the resident's baseline skin temperature' 12. The resident has generalized cyanosis, and Conclusive Sign of Death 13. There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin). Documentation After assessment of the resident is completed and appropriate interventions taken, documentation of the circumstances and the assessment of the resident in the resident record are a requirement. The rules of the BON establish legal documentation standards (BON Standards of Nursing Practice, 22 TAC § Rule 217.1 (1)(D)). Examples of important documentation elements include: Description of discovery of the resident Any treatment of [REDACTED]. The findings of each of the assessment elements outlined in the standards All individuals notified of the resident's status (e.g., [DATE], the health care provider, the administrator of the facility, family, coroner, etc. Any directions that were provided to staff or others during the assessment and/or treatment of [REDACTED].> The results of any communications Presence or absence of witnesses Documentation should be adequate to give a clear picture of the situation and all the actions that were taken or not taken on behalf of the resident.

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F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) Even if the nurse's decision not to initiate CPR was appropriate, failure to document can result in an action against a nurse's license by the BON. Furthermore, lack of documentation places the nurse at a disadvantage should the nurse be required to explain the circumstances of the resident's death. Registered nurses should be aware that actions documented at the time of death provide a much more credible and accurate clinical description. Documentation that is absent, incomplete or inaccurate reveals gaps in care, requiring the nurse to prove actions not appropriately documented were actually taken . RN Role in Pronouncement of Death Texas law provides for RN pronouncement of death (Health & Safety Code §§ 671.001 - .002). The law requires that for a nurse to pronounce death, the facility must have a written policy which is jointly developed and approved by the medical staff or medical consultant and the nursing staff, specifying under what circumstances a RN can make a pronouncement of death. It is important that nurses understand that the assessment that death has occurred and that CPR is not an appropriate intervention are not the equivalent to the pronouncement of death, Texas statutory law governs who can pronounce death, and only someone legally authorized to pronounce death may do so. If the RN does not have the authority to pronounce death, upon assessment of death the RN must notify a person legally authorized to pronounce death. Qualifier to Position The BON evaluates failure to initiate CPR cases based on the premise that in the absence of a physician's DNR order it is generally outside the standard of nursing practice not to initiate CPR. Consequently, RNs deciding not to initiate CPR when not all seven signs of death are present, must assure themselves that not initiating CPR complies with their respective standards of practice. Depending on the circumstances, a nurse's failure to initiate CPR when not all seven signs are present may constitute failure to comply with the standards of nursing care. This position statement is limited to situations when all seven signs are present and should not be construed as providing guidance on the appropriateness of not initiating CPR when not all seven signs are present. The facility's plan of removal of Immediate Jeopardy was accepted as being completed on [DATE]. The plan included the following: 1. CPR, Assessment, Neglect a. DON/designee inserviced licensed nurses on the revised facility CPR policy, including honoring resident wishes and the RN's responsibility according to the BON scope of practice. RN involved in the event and licensed nurses were inserviced on the CPR policy in place during the event by regional nurse and ADON on the date of occurrence [DATE] through [DATE] and again on the revised CPR policy on [DATE] by the regional nurse. No licensed nurse will work prior to receiving inservices from this point forward. Inservicing to be complete by 2PM [DATE]. b. DON/designee inserviced licensed nurses on change in condition, notification and detailed documentation of assessment/evaluation findings. No licensed nurse will work prior to receiving inservices from this point forward. Inservices to be complete by 2PM [DATE]. c. CPR classes were held (MONTH) 2, (YEAR), by American Heart Association. Additional online classes were also completed. All licensed nurses have current CPR certifications. The Business Office Manager will monitor the expiration dates on a monthly basis and notify the DON on upcoming expirations. d. DON/designee provided abuse/neglect inservice to licensed facility staff on [DATE]. No licensed nurse will work prior to receiving inservices. Completed by 2PM [DATE]. e. Licensed nurses will complete a post test on inservice information to monitor effectiveness of training and staff comprehension and will be completed by [DATE]. f. New hires and Agency staff will receive the inservices prior to working their shift from this point forward. PRN staff who choose not to come in for inservices will be terminated and removed from the system. Staff who are on vacation and cannot be reached will not return to work until they receive the education. g. Admin/DON/Medical Director reviewed and revised CPR policy to include withholding CPR on [DATE] and was signed by the Medical Director on [DATE]. h. DON/designee will review code status changes during clinical start up meeting and present any identified trends to QAPI monthly for 3 months for additional analysis and recommendations. i. DON/designee conducted Mock Code Blue drills on [DATE] and [DATE] and will continue to be completed monthly on alternating shifts for three months. Next one is scheduled for [DATE]. j. Administrator will review clinical start-up checklist weekly for 3 months, ending [DATE]. Verification of the Plan of removal was conducted [DATE] and [DATE]. Four licensed nurses were interviewed on [DATE] and [DATE]. All four verbalized the steps to follow for an unresponsive full code resident: Yell for help, direct someone to call 911, direct someone to get crash cart and call the code; in the meantime, prepare to do CPR, do not leave the resident, and do not stop CPR until EMS takes over or doctor orders to stop. Review of the Advance Directives and Code Status Report dated [DATE] listed 49 resident as Full Code.
F 0610 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to have evidence that all allegations of neglect were thoroughly investigated and preventative interventions were implemented to prevent further neglect from occurring for 1 of 3 residents reviewed for neglect. (Resident #1). The facility failed to: a) initiate CPR for Resident #1 when he was found unresponsive, with no respirations and no pulse. Resident #1 was a full code. Resident #1 was pronounced dead in the facility by RN A on [DATE] at 8:17 AM. b) ensure all licensed nursing staff were inserviced on resident neglect, code status, performing CPR, documentation, and c) ensure all licensed nursing staff had current CPR certification. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at a level of actual harm with a scope of isolated due to the facility's need to complete training of all staff and monitor the plan of removal. This failure affected one resident who died on [DATE] and could place 49 residents who were documented as requesting full code status at risk of not being provided resuscitation, which could lead to death. Findings include: Review of Resident #1's undated Face Sheet indicated he was [AGE] years old and was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #1's MDS assessment dated [DATE] indicated he had moderate cognitive impairment. He was occasionally incontinent of urine and frequently incontinent of bowel. He required limited assistance of one person for ADLs. Review of Resident #1's Physician order [REDACTED].>Review of Resident #1's Baseline Care Plan dated [DATE] indicated his goal was to discharge to the community. Review of a nurse's note dated [DATE] at 10:59 A.M., by RN A, included the following: Skilled nursing svcs (services), DX: acute kidney failure, diabetes, [MEDICAL CONDITION]. @ 06:15 went to Room B7 to check blood sugar level. The blood sugar was 157 and 6 units Humalog were given to abdomen. Resident was conversant and remained lying down during entire procedure. I left the room and continued on with my blood sugar checks. At 8:15 the aides were summoning me to B7 because Resident appeared to have passed. I assessed with [REDACTED]. I determined deceased at 8:17. I notified resident physician and family at 8:30 and notified staff of the deceased . Review of nurse's note dated [DATE] at 15:10 (3:10 PM), by RN A, included the following: Addendum to [DATE]; 10:59 AM entry. When I was assessing resident (#1) for signs of life I noted that the resident was unresponsive with cold fingers. His face was very blue. Eyes were fixated with no response to light. I listened with stethoscope to all lung and heart regions with no response. I checked for pulses in the carotid arteries as well as brachial pulses. No pulses and no respiration. Exterior distal extremities were cold to touch and very pale. I noted cyanosis in the abdominal region. Resident was lying on the left side with face turned to left. There were no emissions of bodily fluids from mouth or bowels. No odor was present. The left side was darkened by blood pooling. Review of the Provider Investigation Report dated [DATE] included the following Investigation Summary: The Administrator conducted the investigation through review of the Texas Board of Nursing statements/statutes, medical records and staff

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) interviews. At 0615 on [DATE] (RN A) entered (Resident #1's) room to conduct a blood sugar check and administer insulin prior to his meal. (Resident #1) was awake and responsive to (RN A's) conversation. Between 0715 and 0730, (CNA B) took (Resident #1) his breakfast tray and appeared to be sleeping. (Resident #1 did not respond to (CNA B's) good morning. At between 0800 - 0815, (CNA B) went back to pick up the tray and (Resident #1) had not touched his food. (CNA B) attempted to arouse (Resident #1) and got no response. At that point, (CNA B) felt for a pulse and did not feel one. She caught another CNA in the hallway and had them go get (RN A). At 0815 (RN A) came into the room and attempted to arouse (Resident #1). He was still unresponsive so (RN A) performed a sternum rub and (Resident #1) was still unresponsive. (RN A) then assessed (Resident #1) for pulse, respirations and eye dilitations (sp). None were present. (RN A) noted (Resident #1's) face was blue and extremities were cold to the touch. (RN A) pronounced his death at 0817 and notified the attending physician and family around 0830. The Administrator finds this unconfirmed for neglect due to the RN [MEDICATION NAME] within his scope of practice according to the TBON. Review of the inservice records dated ,[DATE] and [DATE] indicated that 8 of 19 current licensed nursing staff had not received inservicing on resident neglect, code status, performing CPR, documentation. Review of licensed nursing staff personnel files revealed 14 out of 20 nurses, including the DON, did not have current CPR certifications at the time of Resident #1's death. RN A's CPR certification expired (MONTH) (YEAR). LVN C's CPR certification was current, expiring (MONTH) 2019. Further review of the personnel files revealed that all licensed nursing staff had current CPR certification at the time of this investigation, except the DON. Her certification expired (MONTH) (YEAR). In an interview on [DATE] at 9:40 AM with the DON, she said the corporation added the BON statement on the RN Role in Withholding CPR . after the incident. (the previous Medical Director) signed it on [DATE]. We can follow the BON, we just added it to the policy to make it clear. Regarding CPR certification, she said she just hasn't had time to do it yet, but will do so soon. Regarding the licensed nurses inservices, she said she thinks there is another sign-in page somewhere, but they cannot find it. She said she thought that all licensed nurses had received the inservice training. In an interview with RN A on [DATE] at 10:10 AM he said he checked Resident #1's blood sugar at 6:10 AM, with a result of 157. He gave the resident 6 units of Humalog insulin (5 units ordered 3 times daily and 1 unit per sliding scale for blood sugar of 150 - 175). RN A said Resident #1 kind of came awake while he was checking his blood sugar and administering insulin. Afterwards, RN A said he went to the next hall to continue his rounds with other residents. RN A said that approximately 8:15 AM CNA B came to get him to come to Resident #1's room. He said the resident's face was blue, there was pooling in his abdomen, he was laying on his left side and the left side of his abdomen was kind of purplish. He said his eyes were glassy and his fingers were cold. He had no pulse or respirations. He said there was evidence of cyanosis, his face was real blue. RN A was unable to describe Resident #1's extremities looked like. He said, I didn't take his clothes off. RN A said he wrote the addendum nurse's note after he talked to the facility administrator and was told he needed more documentation, nothing specific, just more complete documentation. In an interview with the facility administrator he said they had a conference call with the RNC after Resident #1 death. He said the RNC had questions that were not in RN A's original nurse's note. He said he had RN A do the addendum to include the information he told us on the conference call. In a telephone interview with CNA B on [DATE] at 10:30 AM she said the day Resident #1 died was her second day of orientation. She said that she and the other CNAs were passing out breakfast trays on the halls. She said she was told that Resident #1 would eat when he wakes up, and to just leave his tray for him. She said when she came back after breakfast, she told him she was going to take his tray, and he didn't respond. She said he was lying on his back and she noticed his hands were cold. She checked for a pulse and saw he wasn't breathing. She said she didn't notice any skin discoloration, he looked the same to her. She said CNA D was picking up trays across the hall and she called her to Resident #1's room. She walked in and asked if he was okay, then went to get a nurse. LVN C came to the room and told CNA B to go get RN A. In a telephone interview with LVN C on [DATE] at 10:43 AM she said One of the girls down the hall said they needed help. RN A was down another hall. I called out to him and we went to Resident #1's room. He was unresponsive. RN A shook his arm. He wasn't breathing. He was on his back with a pillow under his head. His tray was there, and it looked like he had eaten and gone back to sleep. The cover was off the tray with food eaten. LVN C said she had never seen Resident #1 before as she works other halls. LVN C could not describe the appearance of Resident #1's face. In a telephone interview with CNA D on [DATE] at 11:15 AM she works part time. On the day Resident #1 died she said she worked 8:00 AM - 2:00 PM. She said they (the CNA's) were picking up breakfast trays. Resident #1's room was on the right side of the hall and she was picking up trays on the left side of the hall. CNA B came out of his room and told me to get a nurse. I got (LVN C) from the rotunda. She came and checked Resident #1 and said to go get RN A. He came and checked (the resident). Me and (CNA B) left with his tray. She said nothing on his breakfast tray was touched. She said he would usually sit in the recliner for his meals. When I checked his pulse, he was cold. I turned off the air conditioner. He was down in the bed. He looked like he was asleep with lots of blankets and the AC on cold. That's how he liked it. He was uncovered to the chest and his left arm was out. He was on his back. His skin on his arm was kind of purple red. His face was flushed, his cheeks purplish red. His mouth was open, and his eyes were closed with tears puddled in the corners. RN A was in a lot of shock. We (the CNAs) left the room and LVN C was behind us I think. She said that neither of the nurses told them to call 911. In an interview with RN A on [DATE] at 11:57 AM he said he knew that Resident #1 was a full code when he was found unresponsive. He said he decided not to do CPR because it had been too long. He said Resident #1 had a 4-inch diameter area of pooling on his left abdomen. He said he did not turn the resident to further assess for lividity. In a telephone interview with RN A on [DATE] at 3:44 PM he said he did not initiate CPR for Resident #1 because too much time had passed, he hadn't touched his breakfast. He said he did not know specifically what the facility policy was at the time regarding CPR. He said there was an in-service the following day or so regarding what to do when a resident is found unresponsive: Call 911 and get the firemen; start CPR; let the paramedics make the call. He said he thought the facility had held mock codes in the past, but he had not attended. He said, All of us were supposed to have CPR certification. In an interview with RN A on [DATE] at 11:10 AM, (with the DON in attendance at RN A's request) in Resident #1's previous room, RN A demonstrated how the resident was lying on the bed and described the events of the morning of [DATE]: The bed was against the wall with the right side of the bed next to the window AC unit. RN A said that Resident #1 was usually groggy in the mornings. He said a CNA delivered his breakfast at approximately 7:30 AM. He said that he was on C hall at approximately 8:15 AM when CNA B came to get him to go to Resident #1's room. The resident was lying on his left side. His face was very blue. RN A said he went to the nurses' desk to get his stethoscope. When he returned he did a sternal rub on Resident #1 without response. He checked the resident's eyes with a penlight and there was no pupil reaction. He said the felt the resident's fingers and they were cold. He said he was covered from waist down with blankets. He had a shirt on. He said there was an approximately 4-inch circumference discoloration on his left abdomen. He said that after his assessment of the resident he returned to the nurses' station and called the resident's doctor and his family regarding his death. He then told the Interim DON and the ADON. The Administrator, DON and RNC were notified of the Immediate Jeopardy situation on [DATE] at 3:55 PM. In a telephone interview on [DATE] at 11:10 AM with the facility Medical Director who was also Resident #1's primary physician, he said he did not remember exactly what RN A had said when he called him and reported Resident #1's death at the facility, as he did not have immediate access to his records. He was notified of the Immediate Jeopardy situation. He said that for a resident who was a full code he would expect the nursing staff to start CPR and call 911. He said he was not aware, until now, of the circumstances of Resident#1's death. Review of the facility's Code Status System, revised [DATE], included the following, in part: Green alerts (located in the front of the clinical record) indicate the resident's desire to have CPR and every attempt to provide all heroic measures must be recognized. Review of www.bon.texas.gov/practice_wposition_statements_content.asp#15.20 accessed [DATE], include the following, in part: approved by the Board of Nursing (MONTH) 24, 2002, and last revised ,[DATE], included the following, in part: 15.20 Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility The Texas Board of Nursing (BON) has approved this position statement, only applicable to long term care settings, in an effort to provide guidance to registered nurse in long-term care facilities and to clarify issues of [MEDICATION NAME] end-of-life care .

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Assessment of death in which CPR would be a futile and inappropriate intervention requires that all seven of the following signs be present and that the arrest is unwitnessed: Presumptive Signs of Death 1. The resident is unresponsive; 2. The resident has no respirations; 3. The resident has no pulse; 4. Resident's pupils are fixed and dilated; 5. The resident's body temperature indicates hypothermia: skin is cold relative to the resident's baseline skin temperature; 6. The resident has generalized cyanosis; and Conclusive Sign of Death 7. There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin). RN Role in Withholding CPR With an Unwitnessed Arrest Pronouncement of Death There may be a time when initiating CPR is not [MEDICATION NAME] or is futile. The Texas Board of Nursing has provided the following position statement for an unwitnessed arrest AND pronouncing death: Unwitnessed Arrest In the case of an unwitnessed resident arrest without DNR orders, determination of the appropriateness of CPR initiation should be undertaken by the registered nurse through a resident assessment, and interventions appropriate to the findings initiated. Assessment of death in which CPR would be a futile and inappropriate intervention requires that all seven of the following signs be present and that the arrest is unwitnessed. Presumptive Signs of Death 8. The resident is unresponsive, 9. The resident has no respirations, 10. The resident has no pulse, a. Resident's pupils are fixed and dilated. 11. The resident's body temperature indicates hypothermia: skin is cold relative to the resident's baseline skin temperature' 12. The resident has generalized cyanosis, and Conclusive Sign of Death 13. There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin). Documentation After assessment of the resident is completed and appropriate interventions taken, documentation of the circumstances and the assessment of the resident in the resident record are a requirement. The rules of the BON establish legal documentation standards (BON Standards of Nursing Practice, 22 TAC § Rule 217.1 (1)(D)). Examples of important documentation elements include: Description of discovery of the resident Any treatment of [REDACTED]. The findings of each of the assessment elements outlined in the standards All individuals notified of the resident's status (e.g., [DATE], the health care provider, the administrator of the facility, family, coroner, etc. Any directions that were provided to staff or others during the assessment and/or treatment of [REDACTED].> The results of any communications Presence or absence of witnesses Documentation should be adequate to give a clear picture of the situation and all the actions that were taken or not taken on behalf of the resident. Even if the nurse's decision not to initiate CPR was appropriate, failure to document can result in an action against a nurse's license by the BON. Furthermore, lack of documentation places the nurse at a disadvantage should the nurse be required to explain the circumstances of the resident's death. Registered nurses should be aware that actions documented at the time of death provide a much more credible and accurate clinical description. Documentation that is absent, incomplete or inaccurate reveals gaps in care, requiring the nurse to prove actions not appropriately documented were actually taken . RN Role in Pronouncement of Death Texas law provides for RN pronouncement of death (Health & Safety Code §§ 671.001 - .002). The law requires that for a nurse to pronounce death, the facility must have a written policy which is jointly developed and approved by the medical staff or medical consultant and the nursing staff, specifying under what circumstances a RN can make a pronouncement of death. It is important that nurses understand that the assessment that death has occurred and that CPR is not an appropriate intervention are not the equivalent to the pronouncement of death, Texas statutory law governs who can pronounce death, and only someone legally authorized to pronounce death may do so. If the RN does not have the authority to pronounce death, upon assessment of death the RN must notify a person legally authorized to pronounce death. Qualifier to Position The BON evaluates failure to initiate CPR cases based on the premise that in the absence of a physician's DNR order it is generally outside the standard of nursing practice not to initiate CPR. Consequently, RNs deciding not to initiate CPR when not all seven signs of death are present, must assure themselves that not initiating CPR complies with their respective standards of practice. Depending on the circumstances, a nurse's failure to initiate CPR when not all seven signs are present may constitute failure to comply with the standards of nursing care. This position statement is limited to situations when all seven signs are present and should not be construed as providing guidance on the appropriateness of not initiating CPR when not all seven signs are present. The facility's plan of removal of Immediate Jeopardy was accepted as being completed on [DATE]. The plan included the following: 1. CPR, Assessment, Neglect a. DON/designee inserviced licensed nurses on the revised facility CPR policy, including honoring resident wishes and the RN's responsibility according to the BON scope of practice. RN involved in the event and licensed nurses were inserviced on the CPR policy in place during the event by regional nurse and ADON on the date of occurrence [DATE] through [DATE] and again on the revised CPR policy on [DATE] by the regional nurse. No licensed nurse will work prior to receiving inservices from this point forward. Inservicing to be complete by 2PM [DATE]. b. DON/designee inserviced licensed nurses on change in condition, notification and detailed documentation of assessment/evaluation findings. No licensed nurse will work prior to receiving inservices from this point forward. Inservices to be complete by 2PM [DATE]. c. CPR classes were held (MONTH) 2, (YEAR), by American Heart Association. Additional online classes were also completed. All licensed nurses have current CPR certifications. The Business Office Manager will monitor the expiration dates on a monthly basis and notify the DON on upcoming expirations. d. DON/designee provided abuse/neglect inservice to licensed facility staff on [DATE]. No licensed nurse will work prior to receiving inservices. Completed by 2PM [DATE]. e. Licensed nurses will complete a post test on inservice information to monitor effectiveness of training and staff comprehension and will be completed by [DATE]. f. New hires and Agency staff will receive the inservices prior to working their shift from this point forward. PRN staff who choose not to come in for inservices will be terminated and removed from the system. Staff who are on vacation and cannot be reached will not return to work until they receive the education. g. Admin/DON/Medical Director reviewed and revised CPR policy to include withholding CPR on [DATE] and was signed by the Medical Director on [DATE]. h. DON/designee will review code status changes during clinical start up meeting and present any identified trends to QAPI monthly for 3 months for additional analysis and recommendations. i. DON/designee conducted Mock Code Blue drills on [DATE] and [DATE] and will continue to be completed monthly on

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F 0610 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 5) alternating shifts for three months. Next one is scheduled for [DATE]. j. Administrator will review clinical start-up checklist weekly for 3 months, ending [DATE]. Verification of the Plan of removal was conducted [DATE] and [DATE]. Four licensed nurses were interviewed on [DATE] and [DATE]. All four verbalized the steps to follow for an unresponsive full code resident: Yell for help, direct someone to call 911, direct someone to get crash cart and call the code; in the meantime, prepare to do CPR, do not leave the resident, and do not stop CPR until EMS takes over or doctor orders to stop. Review of the Advance Directives and Code Status Report dated [DATE] listed 49 resident as Full Code.
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that Resident #1 received treatment and care in accordance with professional standards of practice for one (Resident #1) of three residents reviewed quality of care. The facility did not initiate CPR for Resident #1 when he was found unresponsive, with no respirations and no pulse. Resident #1 was a full code. Resident #1 was pronounced dead in the facility by RN A at 8:17 AM on [DATE]. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at a level of actual harm with a scope identified as isolated due to the facility's need to complete training of all staff and monitor the plan of removal. This failure affected one resident who died on [DATE] and could place 49 residents who were documented as requesting full code status at risk of not being provided resuscitation, which could lead to death. Findings include: Review of Resident #1's undated Face Sheet indicated he was [AGE] years old and was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #1's MDS assessment dated [DATE] indicated he had moderate cognitive impairment. He was occasionally incontinent of urine and frequently incontinent of bowel. He required limited assistance of one person for ADLs. Review of Resident #1's Physician order [REDACTED].>Review of Resident #1's Baseline Care Plan dated [DATE] indicated his goal was to discharge to the community. Review of a nurse's note dated [DATE] at 10:59 A.M., by RN A, included the following: Skilled nursing svcs (services), DX: acute kidney failure, diabetes, [MEDICAL CONDITION]. @ 06:15 went to Room B7 to check blood sugar level. The blood sugar was 157 and 6 units Humalog were given to abdomen. Resident was conversant and remained lying down during entire procedure. I left the room and continued on with my blood sugar checks. At 8:15 the aides were summoning me to B7 because Resident appeared to have passed. I assessed with [REDACTED]. I determined deceased at 8:17. I notified resident physician and family at 8:30 and notified staff of the deceased . Review of nurse's note dated [DATE] at 15:10 (3:10 PM), by RN A, included the following: Addendum to [DATE]; 10:59 entry. When I was assessing resident (#1) for signs of life I noted that the resident was unresponsive with cold fingers. His face was very blue. Eyes were fixated with no response to light. I listened with stethoscope to all lung and heart regions with no response. I checked for pulses in the carotid arteries as well as brachial pulses. No pulses and no respiration. Exterior distal extremities were cold to touch and very pale. I noted cyanosis in the abdominal region. Resident was lying on the left side with face turned to left. There were no emissions of bodily fluids from mouth or bowels. No odor was present. The left side was darkened by blood pooling. Review of the Provider Investigation Report dated [DATE] included the following Investigation Summary: The Administrator conducted the investigation through review of the Texas Board of Nursing statements/statutes, medical records and staff interviews. At 0615 on [DATE] (RN A) entered (Resident #1's) room to conduct a blood sugar check and administer insulin prior to his meal. (Resident #1) was awake and responsive to (RN A's) conversation. Between 0715 and 0730, (CNA B) took (Resident #1) his breakfast tray and appeared to be sleeping. (Resident #1 did not respond to (CNA B's) good morning. At between 0800 - 0815, (CNA B) went back to pick up the tray and (Resident #1) had not touched his food. (CNA B) attempted to arouse (Resident #1) and got no response. At that point, (CNA B) felt for a pulse and did not feel one. She caught another CNA in the hallway and had them go get (RN A). At 0815 (RN A) came into the room and attempted to arouse (Resident #1). He was still unresponsive so (RN A) performed a sternum rub and (Resident #1) was still unresponsive. (RN A) then assessed (Resident #1) for pulse, respirations and eye dilitations (sp). None were present. (RN A) noted (Resident #1's) face was blue and extremities were cold to the touch. (RN A) pronounced his death at 0817 and notified the attending physician and family around 0830. The Administrator finds this unconfirmed for neglect due to the RN [MEDICATION NAME] within his scope of practice according to the TBON. In an interview on [DATE] at 9:40 AM with the DON, she said the corporation added the BON statement on the RN Role in Withholding CPR . after the incident. (the previous Medical Director) signed it on [DATE]. We can follow the BON, we just added it to the policy to make it clear . In an interview with RN A on [DATE] at 10:10 AM he said he checked Resident #1's blood sugar at 6:10 AM, with a result of 157. He gave the resident 6 units of Humalog insulin (5 units ordered 3 times daily and 1 unit per sliding scale for blood sugar of 150 - 175). RN A said Resident #1 kind of came awake while he was checking his blood sugar and administering insulin. Afterwards, RN A said he went to the next hall to continue his rounds with other residents. RN A said that approximately 8:15 AM CNA B came to get him to come to Resident #1's room. He said the resident's face was blue, there was pooling in his abdomen, he was laying on his left side and the left side of his abdomen was kind of purplish. He said his eyes were glassy and his fingers were cold. He had no pulse or respirations. He said there was evidence of cyanosis, his face was real blue. RN A was unable to describe Resident #1's extremities looked like. He said, I didn't take his clothes off. RN A said he wrote the addendum nurse's note after he talked to the facility administrator and was told he needed more documentation, nothing specific, just more complete documentation. In an interview with the facility administrator he said they had a conference call with the RNC after Resident #1 death. He said the RNC had questions that were not in RN A's original nurse's note. He said he had RN A do the addendum to include the information he told us on the conference call. In a telephone interview with CNA B on [DATE] at 10:30 AM she said the day Resident #1 died was her second day of orientation. She said that she and the other CNAs were passing out breakfast trays on the halls. She said she was told that Resident #1 would eat when he wakes up, and to just leave his tray for him. She said when she came back after breakfast, she told him she was going to take his tray, and he didn't respond. She said he was lying on his back and she noticed his hands were cold. She checked for a pulse and saw he wasn't breathing. She said she didn't notice any skin discoloration, he looked the same to her. She said CNA D was picking up trays across the hall and she called her to Resident #1's room. She walked in and asked if he was okay, then went to get a nurse. LVN C came to the room and told CNA B to go get RN A. In a telephone interview with LVN C on [DATE] at 10:43 AM she said One of the girls down the hall said they needed help. RN A was down another hall. I called out to him and we went to Resident #1's room. He was unresponsive. RN A shook his arm. He wasn't breathing. He was on his back with a pillow under his head. His tray was there, and it looked like he had eaten and gone back to sleep. The cover was off the tray with food eaten. LVN C said she had never seen Resident #1 before as she works other halls. LVN C could not describe the appearance of Resident #1's face. In a telephone interview with CNA D on [DATE] at 11:15 AM she works part time. On the day Resident #1 died she said she worked 8:00 AM - 2:00 PM. She said they (the CNA's) were picking up breakfast trays. Resident #1's room was on the right side of the hall and she was picking up trays on the left side of the hall. CNA B came out of his room and told me to get a nurse. I got (LVN C) from the rotunda. She came and checked Resident #1 and said to go get RN A. He came and checked (the resident). Me and (CNA B) left with his tray. She said nothing on his breakfast tray was touched. She said he would usually sit in the recliner for his meals. When I checked his pulse, he was cold. I turned off the air conditioner. He was down in the bed. He looked like he was asleep with lots of blankets and the AC on cold. That's how he liked it. He was uncovered to the chest and his left arm was out. He was on his back. His skin on his arm was kind of purple red. His face was flushed, his cheeks purplish red. His mouth was open, and his eyes were closed with tears puddled in the corners. RN A was in a lot of shock. We (the CNAs) left the room and LVN C was behind us I think. She said that neither of the nurses told them to

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) call 911. In an interview with RN A on [DATE] at 11:57 AM he said he knew that Resident #1 was a full code when he was found unresponsive. He said he decided not to do CPR because it had been too long. He said Resident #1 had a 4-inch diameter area of pooling on his left abdomen. He said he did not turn the resident to further assess for lividity. In a telephone interview with RN A on [DATE] at 3:44 PM he said he did not initiate CPR for Resident #1 because too much time had passed, he hadn't touched his breakfast. He said he did not know specifically what the facility policy was at the time regarding CPR. He said there was an in-service the following day or so regarding what to do when a resident is found unresponsive: Call 911 and get the firemen; start CPR; let the paramedics make the call. He said he thought the facility had held mock codes in the past, but he had not attended. He said, All of us were supposed to have CPR certification. Review of licensed nursing staff personnel files revealed 14 out of 20 nurses, including the DON, did not have current CPR certifications at the time of Resident #1's death. RN A's CPR certification expired (MONTH) (YEAR). LVN C's CPR certification was current, expiring (MONTH) 2019. In an interview with RN A on [DATE] at 11:10 AM, (with the DON in attendance at RN A's request) in Resident #1's previous room, RN A demonstrated how the resident was lying on the bed and described the events of the morning of [DATE]: The bed was against the wall with the right side of the bed next to the window AC unit. RN A said that Resident #1 was usually groggy in the mornings. He said a CNA delivered his breakfast at approximately 7:30 AM. He said that he was on C hall at approximately 8:15 AM when CNA B came to get him to go to Resident #1's room. The resident was lying on his left side. His face was very blue. RN A said he went to the nurses' desk to get his stethoscope. When he returned he did a sternal rub on Resident #1 without response. He checked the resident's eyes with a penlight and there was no pupil reaction. He said the felt the resident's fingers and they were cold. He said he was covered from waist down with blankets. He had a shirt on. He said there was an approximately 4-inch circumference discoloration on his left abdomen. He said that after his assessment of the resident he returned to the nurses' station and called the resident's doctor and his family regarding his death. He then told the Interim DON and the ADON. The Administrator, DON and RNC were notified of the Immediate Jeopardy situation on [DATE] at 3:55 PM. In a telephone interview on [DATE] at 11:10 AM with the facility Medical Director who was also Resident #1's primary physician, he said he did not remember exactly what RN A had said when he called him and reported Resident #1's death at the facility, as he did not have immediate access to his records. He was notified of the Immediate Jeopardy situation. He said that for a resident who was a full code he would expect the nursing staff to start CPR and call 911. He said he was not aware until now of the circumstances of Resident#1's death. Review of the facility's Code Status System, revised [DATE], included the following, in part: Green alerts (located in the front of the clinical record) indicate the resident's desire to have CPR and every attempt to provide all heroic measures must be recognized. Review of www.bon.texas.gov/practice_wposition_statements_content.asp#15.20 accessed [DATE], include the following, in part: approved by the Board of Nursing (MONTH) 24, 2002, and last revised ,[DATE], included the following, in part: 15.20 Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility The Texas Board of Nursing (BON) has approved this position statement, only applicable to long term care settings, in an effort to provide guidance to registered nurse in long-term care facilities and to clarify issues of [MEDICATION NAME] end-of-life care . Assessment of death in which CPR would be a futile and inappropriate intervention requires that all seven of the following signs be present and that the arrest is unwitnessed: Presumptive Signs of Death 1. The resident is unresponsive; 2. The resident has no respirations; 3. The resident has no pulse; 4. Resident's pupils are fixed and dilated; 5. The resident's body temperature indicates hypothermia: skin is cold relative to the resident's baseline skin temperature; 6. The resident has generalized cyanosis; and Conclusive Sign of Death 7. There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin). RN Role in Withholding CPR With an Unwitnessed Arrest Pronouncement of Death There may be a time when initiating CPR is not [MEDICATION NAME] or is futile. The Texas Board of Nursing has provided the following position statement for an unwitnessed arrest AND pronouncing death: Unwitnessed Arrest In the case of an unwitnessed resident arrest without DNR orders, determination of the appropriateness of CPR initiation should be undertaken by the registered nurse through a resident assessment, and interventions appropriate to the findings initiated. Assessment of death in which CPR would be a futile and inappropriate intervention requires that all seven of the following signs be present and that the arrest is unwitnessed. Presumptive Signs of Death 8. The resident is unresponsive, 9. The resident has no respirations, 10. The resident has no pulse, a. Resident's pupils are fixed and dilated. 11. The resident's body temperature indicates hypothermia: skin is cold relative to the resident's baseline skin temperature' 12. The resident has generalized cyanosis, and Conclusive Sign of Death 13. There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin). Documentation After assessment of the resident is completed and appropriate interventions taken, documentation of the circumstances and the assessment of the resident in the resident record are a requirement. The rules of the BON establish legal documentation standards (BON Standards of Nursing Practice, 22 TAC § Rule 217.1 (1)(D)). Examples of important documentation elements include: Description of discovery of the resident Any treatment of [REDACTED]. The findings of each of the assessment elements outlined in the standards All individuals notified of the resident's status (e.g., [DATE], the health care provider, the administrator of the facility, family, coroner, etc. Any directions that were provided to staff or others during the assessment and/or treatment of [REDACTED].> The results of any communications Presence or absence of witnesses Documentation should be adequate to give a clear picture of the situation and all the actions that were taken or not taken on behalf of the resident. Even if the nurse's decision not to initiate CPR was appropriate, failure to document can result in an action against a nurse's license by the BON. Furthermore, lack of documentation places the nurse at a disadvantage should the nurse be required to explain the circumstances of the resident's death. Registered nurses should be aware that actions documented at the time of death provide a much more credible and accurate clinical description. Documentation that is absent, incomplete or inaccurate reveals gaps in care, requiring the nurse to prove actions not appropriately documented were actually taken . RN Role in Pronouncement of Death Texas law provides for RN pronouncement of death (Health & Safety Code §§ 671.001 - .002). The law requires that for a nurse to pronounce death, the facility must have a written policy which is jointly developed and approved by the medical staff or medical consultant and the nursing staff, specifying under what circumstances a RN can make a pronouncement of death. It is important that nurses understand that the assessment that death has occurred and that CPR is not an appropriate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675932	A. BUILDING _____ B. WING _____	**08/06/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR TERRACE HEALTHCARE CENTER	**609 RIO CONCHO DR SAN ANGELO, TX 76903**

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) intervention are not the equivalent to the pronouncement of death, Texas statutory law governs who can pronounce death, and only someone legally authorized to pronounce death may do so. If the RN does not have the authority to pronounce death, upon assessment of death the RN must notify a person legally authorized to pronounce death. Qualifier to Position The BON evaluates failure to initiate CPR cases based on the premise that in the absence of a physician's DNR order it is generally outside the standard of nursing practice not to initiate CPR. Consequently, RNs deciding not to initiate CPR when not all seven signs of death are present, must assure themselves that not initiating CPR complies with their respective standards of practice. Depending on the circumstances, a nurse's failure to initiate CPR when not all seven signs are present may constitute failure to comply with the standards of nursing care. This position statement is limited to situations when all seven signs are present and should not be construed as providing guidance on the appropriateness of not initiating CPR when not all seven signs are present. The facility's plan of removal of Immediate Jeopardy was accepted as being completed on [DATE]. The plan included the following: 1. CPR, Assessment, Neglect a. DON/designee inserviced licensed nurses on the revised facility CPR policy, including honoring resident wishes and the RN's responsibility according to the BON scope of practice. RN involved in the event and licensed nurses were inserviced on the CPR policy in place during the event by regional nurse and ADON on the date of occurrence [DATE] through [DATE] and again on the revised CPR policy on [DATE] by the regional nurse. No licensed nurse will work prior to receiving inservices from this point forward. Inservicing to be complete by 2PM [DATE]. b. DON/designee inserviced licensed nurses on change in condition, notification and detailed documentation of assessment/evaluation findings. No licensed nurse will work prior to receiving inservices from this point forward. Inservices to be complete by 2PM [DATE]. c. CPR classes were held (MONTH) 2, (YEAR), by American Heart Association. Additional online classes were also completed. All licensed nurses have current CPR certifications. The Business Office Manager will monitor the expiration dates on a monthly basis and notify the DON on upcoming expirations. d. DON/designee provided abuse/neglect inservice to licensed facility staff on [DATE]. No licensed nurse will work prior to receiving inservices. Completed by 2PM [DATE]. e. Licensed nurses will complete a post test on inservice information to monitor effectiveness of training and staff comprehension and will be completed by [DATE]. f. New hires and Agency staff will receive the inservices prior to working their shift from this point forward. PRN staff who choose not to come in for inservices will be terminated and removed from the system. Staff who are on vacation and cannot be reached will not return to work until they receive the education. g. Admin/DON/Medical Director reviewed and revised CPR policy to include withholding CPR on [DATE] and was signed by the Medical Director on [DATE]. h. DON/designee will review code status changes during clinical start up meeting and present any identified trends to QAPI monthly for 3 months for additional analysis and recommendations. i. DON/designee conducted Mock Code Blue drills on [DATE] and [DATE] and will continue to be completed monthly on alternating shifts for three months. Next one is scheduled for [DATE]. j. Administrator will review clinical start-up checklist weekly for 3 months, ending [DATE]. Verification of the Plan of removal was conducted [DATE] and [DATE]. Four licensed nurses were interviewed on [DATE] and [DATE]. All four verbalized the steps to follow for an unresponsive full code resident: Yell for help, direct someone to call 911, direct someone to get crash cart and call the code; in the meantime, prepare to do CPR, do not leave the resident, and do not stop CPR until EMS takes over or doctor orders to stop. Review of the Advance Directives and Code Status Report dated [DATE] listed 49 resident as Full Code.