STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety 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** 35103 Based on interview and record review, the facility failed to provide emergency medical care, including CPR (cardiopulmonary resuscitation), for one Resident (#1) of three residents reviewed for emergency care consistent with physician orders and the resident's advance directives. This deficient practice resulted in Immediate Jeopardy (IJ) when CPR was not performed to restore respiratory and circulatory function, and emergency medical care was not provided at the time Resident #1 was found to be without a pulse. The Immediate Jeopardy began on [DATE] at approximately 6:55 a.m., when Full Code Resident #1 stopped breathing, was without a pulse (heartbeat), and CPR was not performed. The Nursing Home Administrator (NHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON A) were notified at 3:35 p.m. on [DATE] that the [DATE] incident was determined as IJ. The IJ deficient practice was corrected on [DATE], prior to the start of the abbreviated complaint survey, and the deficient practice was therefore deemed Past Non-Compliance. Findings include: This citation relates to Intake #MI00125274. Review of the facility Investigative Summary, received from the NHA on [DATE], revealed Resident #1 was admitted to the facility on [DATE], alert and oriented, documented as responsible for self, and able to make his needs known. Resident #1 was short of breath with audible respiratory gurgling and an oxygen saturation of 79% (percent), at 6:00 a.m. on [DATE]. Resident #1 requested Sudafed medication, and at 6:52 a.m. secretions came out of his mouth, and he took his last breath. At 7:00 a.m., there were no vital signs and no cardiopulmonary resuscitation (CPR); however, he wanted to be resuscitated based on admission notes . (the) DON, reported to the Administrator that [Resident #1] had expired; however, he did not get resuscitated . [Registered Nurse (RN) D], .attending to [Resident #1] was interviewed to find out what transpired before his expiration. [RN D] responded that she did not start CPR as she was unaware of his advance directive . The facility substantiates that [Resident #1] did not have CPR performed on him when he stopped breathing on [DATE]. (continued on next page)

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.

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:02 a.m., Staff C confirmed she provided care for Resident #1 the morning of [DATE]. Staff C stated she responded to Resident #1's call light at about 6:40 a.m., and Resident #1 said he could not breathe, needed his meds, and he requested Sudafed. Staff C stated she then ran and told RN D that Resident #1 could not breathe. RN D gave Staff C a pulse oximeter (to measure oxygen saturation in the blood). Staff C went back to Resident #1, measured his oxygen saturation at 79% (, d+[DATE]% considered normal range). RN D told Staff C to grab an oxygen concentrator from another resident's room. Staff C stated, We hooked him (Resident #1) up with the oxygen (from the oxygen concentrator). He wasn't getting any oxygen. He was very gurgly sounding, and [RN D] said to jack up the oxygen as far as it goes. I put it on five liters, and [RN D] kept saying she should get him a mask (oxygen delivery mask). He could not swallow (the) Sudafed - it was stuck on his tongue - and [RN D] said it would dissolve in his mouth. [RN D] did apply an oxygen delivery face mask . Staff C said Resident #1 was alert and oriented and could hear what was being said. Staff C stayed with Resident #1. Staff C stated, . [RN D] and Licensed Practical Nurse [(LPN) E] were both there. [LPN E] handed [RN D] the stethoscope and [Resident #1's] chest was moving up and down. [RN D] was listening to his lungs. [RN D] said 'he is gone'. He died at five minutes to seven . Staff C stated, You can see 'Full Code' [status on the electronic Medication Administration Record (eMAR)], it was right by the Resident's picture. Staff C confirmed no attempts were made to start CPR on Resident #1. Review of a written To Whom it May Concern letter authored by Staff C, dated [DATE], received from the NHA on [DATE], provided written statement corroborating the sequence of events as told in the above interview. The letter had been provided to the facility NHA following Resident #1's failure to receive CPR per his documented wishes. Review of Resident #1's [DATE] eMAR revealed Advance Directive: Full Code noted near the top left of each page. Review of Resident #1's Medical Treatment Decision Form (MTDF), signed and dated by Resident #1 and two required witnesses on [DATE] and signed by Resident #1's physician on [DATE] revealed the following emergency treatment decision made by Resident #1: CPR Full resuscitation, I request that in the event my heart and breathing should stop, I am given resuscitating measures. Review of Resident #1's Progress Notes revealed the following, in part: [DATE] 17:19 (5:19 p.m.) Resident arrived to facility at 1500 (3:00 p.m.) via medical transport on a stretcher. Resident is alert and oriented. Able to make needs known . [DATE] 17:27 (5:27 p.m.) Resident verbally expresses that he would like CPR should his heart stop. [DATE] [DATE] 11:47 a.m., CNA called this RN (RN D) to resident's room at 0600 (6:00 a.m.), was observed to be short of breath with gurgling, immediately applied oxygen, O2 sats (saturations) were 79% .at 00652 (sic) went back to resident's room and observed medium amount secretion come out and resident took his last breath, no vital signs at 066 (sic). Author RN D. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] 4:11 a.m., Resident complained of secretions and pain throughout the night . [RN D] came out (of Resident #1's room) and said he was 'knocking on deaths door', and a CNA called to her. I (LPN E) followed her (RN D) with my stethoscope so that she could utilize it. When I walked in, he was still breathing, but she was holding his pulse attempting to take a radial pulse and saying he no longer had one. He was still visabaly (sic) engaging in agonal breathing . [RN D] came out saying he had passed . This is written and signed by [LPN E] with permission of [LPN G] due to issues with [Electronic Medical Record]. During an interview on [DATE] at 11:19 a.m., LPN E said she heard Resident #1 calling for assistance around 11 p.m. on [DATE]. Resident #1's call light had fallen to the floor, and he mentioned he was having a hard time breathing. He was in the high 80's (oxygen saturation level), so I elevated the head of the bed. LPN E traded halls with another nurse shortly before 4:00 a.m. on [DATE], and Resident #1 was no longer her patient. LPN E said RN D came out of Resident #1's room around 6:30 a.m. and said his 02 sats were low and he needed to be put on oxygen. About 10 minutes later RN D said he has passed (died). LPN E stated, I was under the assumption that she knew what was happening (regarding Resident #1 being a full code) .About 9:30 a.m., [RN D] mentioned that he was a full-code and she had not initiated CPR. LPN E confirmed their policy: if facility staff were not aware of a resident's code status, CPR was to be initiated. LPN E said she was not asked to write a Witness Statement and would have called a code (to maintain respiration and circulation with CPR), but RN D was the charge nurse. During an interview on [DATE] at 12:14 p.m., LPN G confirmed she had provided care for Resident #1 during the early morning hours on [DATE], but had exited the facility prior to Resident #1's decline. When asked when CPR should be initiated, LPN G stated, With a full code (resident) you would call a code, call for help, get the crash cart and call 911 immediately. When asked about how she would identify a resident's code status, LPN G stated, It is in their chart, and it is in our MAR (Medication Administration Record), under their picture, whether DNR (do not resuscitate) or Full Code. Review of Employee Counseling Notice(s) for RN D on [DATE], and LPN E on [DATE] revealed the following, in part: 1. RN D received a Suspension/Final for Failure to follow facility policy CPR - Adult on [DATE] for [Resident #1] and was Suspended pending investigation. 2. LPN E received a Written Counseling Notice for As a nurse assigned earlier in the shift to the Resident (#1) who later expired/coded, you did not recognize change of condition or express code status (Full Code) to assigned nurse (to) initiate and call a CODE BLUE as required with Education - One on One with ADON (A). During an interview on [DATE] at 11:49 a.m., the NHA, DON, and ADON A all confirmed Resident #1 was a full code, and wanted CPR performed with absence of pulse and/or respiration. The NHA stated, I would have expected them to start CPR, someone starts the code and then another staff member makes the calls to EMS (Emergency Medical Services) and the Doctor . I don't feel that [RN D] did everything (she could have) because if he (Resident #1) asked for Sudafed, she [RN D] would have had to go to the MAR and she would have seen he was a full code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 2:34 p.m., when asked about the failure to perform CPR for Resident #1 on [DATE], RN D stated, I take full responsibility .I should have given the guy CPR, not knowing the code status he was. I don't have any idea why I didn't . I assumed he was a no code (because of his diagnoses) . Review of the Cardiopulmonary Resuscitation (CPR) - Adult policy, revised ,d+[DATE], revealed the following, in part: Policy: Appropriate cardiac and respiratory function will be maintained until a definitive treatment can be given. CPR will be initiated on all residents with an Advanced Directive stating CPR - Full Resuscitation: . It is the policy of this facility to respect each resident's individual, informed decision regarding advance directives and code statuses. Cardiopulmonary Resuscitation (CPR) will be initiated for residents with full code status and residents who have not declared a code status in the event of cardiopulmonary arrest. Policy Explanation and Compliance Guidelines: 1. In the event a resident is identified unresponsive and upon a thorough assessment determines that there is no pulse or respiratory activity, and the resident has declared a full-code status, a licensed staff member will: a. Simultaneously with the initiation of chest compressions direct a staff member to immediately retrieve the crash cart located on the nursing unit. b. Continue to administer chest compressions and rescue respirations per the [Name] recommendations. c. Direct a staff member to contact the Emergency Response Team (911) immediately to inform them of a full code requiring life support interventions and possible transportation to the emergency department . e. Identify a member of the response team to be responsible for documenting the time of each intervention and resulting response . g. Facility staff shall defer all resuscitation efforts to Emergency Response Personnel once they arrive at the location and declare that they will assume the responsibility of maintaining life support interventions. The immediate jeopardy was removed, and the deficient practice corrected on [DATE] after the facility implemented a systemic plan that included the following actions: Action taken for the employee involved: - [RN D] was suspended on [DATE]. - [RN D] personnel file was reviewed on [DATE] by the administrator. The employee had completed background check, reference checks, and abuse training/education on file as well as an up-to-date nursing license. Areas identified requiring quality improvement: - Code status was listed on PCC system (in documents and progress notes) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Incomplete Medical Treatment Decision form (MTDF) on file - Facility reviewed all residents MTDF for code status and updated orders on PCC on [DATE]. Quality Improvement measures or systemic changes made: - Interviews were completed with all necessary individuals starting on [DATE]. - Initiation of a QAA (Quality Assessment and Assurance) Investigation on [DATE] to identify details of the incident and to identify any potential deficient practice that may have occurred in relation to the incident. -The facilities Cardiopulmonary Resuscitation (CPR) - Adult Policy was reviewed on [DATE] and deemed appropriate by the Administrator and Assistant Director of Nursing. - Immediate in-servicing of all RN and LPN facility floor staff was initiated on [DATE]. Any staff member who has not received the education by [DATE] will receive the education prior to start of their next shift. All Licensed Nursing staff were educated on the Cardiopulmonary Resuscitation (CPR) - Adult Policy by [DATE]. A One-to-One in-service on [DATE] was provided by the Administrator to [RN D] via telephone, before working their next shift. Audits were developed for MTDF completion, correct code status in PCC (chart reviews on new admissions). How facility monitors the effectiveness of its quality improvement measures (sustained compliance): - Administrator/designee will conduct new admit chart reviews weekly x (times) 4 weeks and then monthly x 2 months to ensure correct code status, until substantial compliance maintained. Results of these audits will be submitted to the QAA Committee for review and further recommendations. All measures implemented by the facility following Resident #1's lack of emergency medical treatment (including CPR) on [DATE] were reviewed and verified, including quality assurance audits implemented to monitor and maintain continued compliance. The facility was found to be in substantial compliance at the time of this abbreviated survey.