STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395751	A. Building B. Wing	05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Residence and Care Center	174 Virginia Avenue Rochester, PA 15074

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 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** 43210 Based on a review of facility policy, closed resident clinical record, staff interviews, and physician interview, it was determined the facility failed to ensure staff initiated CPR (cardiopulmonary resuscitation - a life saving procedure that is done when breathing or the heartbeat has stopped) to an unresponsive resident resulting in an Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) for one of 70 residents reviewed, Closed Record Resident R1 (CR1). Findings included: Review of facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation last reviewed [DATE], informed Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation (controlled electric shock to restore normal heart rhythm), for victims of sudden cardiac arrest. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or there are obvious signs of irreversible death (e.g. rigor mortis [stiffening of joints and muscles of a body a few hours after death]). If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: instruct a staff to activate the emergency response system (code) and call 911. Instruct a staff member to retrieve the automatic external defibrillator. Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic life support (BLS) sequence of events. The BLS sequence of events is referred to as C-A-B (chest compressions, airway, breathing). All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Continue with CPR/BLS until emergency medical personnel arrive. Review of CR1's clinical recorded revealed the resident was admitted to the facility on [DATE]. Diagnoses included peripheral vascular disease (reduced blood flow to the limbs), dysphagia (difficulty in swallowing food and liquids), hypoglycemia (deficiency of glucose/sugar in the bloodstream) , diabetes (the body's inability to produce or control the hormone insulin resulting in elevated levels of glucose in the blood and urine), end stage renal disease (temporary or permanent damage to the kidneys resulting in loss of normal kidney function), and acquired absence of left leg below the knee (left leg amputation below the knee). (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	Review of CR1's current physician orders dated [DATE], included the resident's code status as CPR, full treatment, use antibiotics, long term intravenous fluids and tube feeding effective [DATE]. Review of CR1's clinical record revealed a POLST (Physician's Order for Life Sustaining Treatment-a medical order specifying the type of medical treatment a person wants in the event of a serious illness) dated [DATE], that indicated the resident wanted CPR initiated with full treatment (CPR, Full Code) to include antibiotics, airway interventions, antibiotics, long term artificial nutrition and hydration. The POLST included the resident's signature. Review of CR1's Minimum Data Set (MDS-periodic assessment of care needs) dated [DATE], indicated a Brief Inventory for Mental Status (BIMS- a screening tool used to determine cognition) score of 15, indicating the resident had no cognitive impairment. Review of CR1's care plan initiated [DATE], included the resident had the potential for alteration in cardiovascular status related to arteriosclerotic heart disease (thickening and hardening of the coronary arteries), coronary artery disease (build up of plaque in the coronary arteries), chronic kideny disease and renal failure. Interventions included to monitor and document for signs and symptoms of cardiac complications: altered mental status, altered level of consciousness, pallor (pale looking), diaphoresis (excessive and abnormal sweating), nausea and vomiting, and to notify the physician for further interventions. Review of CR1's progress notes documented the following: [DATE], at 4:05 a.m. - Resident is nauseated, vomiting, and dry heaving and unable to take anything by PO (by mouth) at this time. [DATE], at 4:06 a.m. - Resident refused dialysis today as they are nauseated, vomiting and dry heaving. [DATE], at 12:36 p.m. - Resident refused PO medications due to nausea. [DATE], at 2:00 p.m. - Resident was administered Zofran Oral Tablet 4 mg for nausea. [DATE], at 10:06 p.m. - Resident in bed all day. Refused dialysis due to nausea. Refused breakfast, lunch, did agree to try clear liquids at dinner, took in hot tea, gingerale, and a few bites of Jello. Physician was contacted due to ongoing nausea, new order for Zofran, adminstered at 2:00 p.m. Re- fused medications throughout day. Complained at 7:00 p.m. of generally not feeling well, achiness all over, feeling hot, sweating, moaning and calling out several times, holding basin (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	due to nausea. Vital signs included blood sugar at 284 (elevated), temperature 97.3 (normal) degrees, pulse 88 beats per minute, respirations 20 breaths per minute, 95% oxygen level, and blood pressure ,d+[DATE] (low). Call placed to physician at 7:20 p.m. and updated on complaints and vital signs, advised to administer Percocet for pain and re- assess. Percocet not on hand to administer, offered Tylenol with resident replying maybe in a little while. Offered Tylenol and cold water at 7:45 p.m. and declined. Entered room at 8:15 p.m. to re-assess resident and was noted to be slumped over to the left side in bed. Extensive mottling (a blotchy red- purplish marbling of the skin occuring when the heart is no longer able to pump blood effectively) noted to entire body, no spontaneous pulse or respirations noted. Per POLST, CPR, Full Treatment. Physician contacted and updated that resident was beyond means of resuscitation and advised to not initiate CPR. Time of death was 8:17 p.m. During an interview on [DATE], at 2:22 p.m. Registered Nurse Employee E1 reported working the 7:00 a.m. to 7:00 p.m. shift on [DATE]. The previous shift relayed that CR1 refused dialysis. The resident reported feeling tired, did not eat or drink. Zofran was administered and the resident had clear liquids. At about 7:00 p. m. the resident felt hot, and the resident's blood sugar was on the lower side. The physician was contacted and requested a pain medication be administered. At 8:15 p.m. Registered Nurse Employee E1 reported finding CR1 slumped over in their bed and found the resident to not be breathing, had no pulse, and was extensively mottled. The nurse left the resident to check the code status and found the resident to be CPR, Full Code. CPR was not initiated. Registered Nurse Employee E1 then called the physician at 8:17 p.m., relayed the observations of the resident, and was instructed to not initiate CPR. Registered Nurse Employee E1 reported Registered Nurse Employee E2, Nursing Assistant Employee E3, Nursing Assistant Employee E4, and Nursing Assistant Employee E6 were also on the unit. Registered Nurse Employee E1 reported Registered Nurse Employee E2 was tied up passing medications and Registered Nurse Employee E1 did not give any instructions to assist as it would have taken more time to explain to registered Nurse Employee E2 on what to do. Registered Nurse Employee E1 reported that the Nursing Assistants were not in plain site. Registered Nurse Employee E1 also reported having to work past the end of their shift, until about 11:00 p. m. During an interview on [DATE], at 3:05 p.m. Registered Nurse Employee E2 reported working the 3:00 p.m. to 3:00 a.m. shift on [DATE]. The nurse reported another nurse came to report CR1 had ceased to breathe. Registered Nurse Employee E2 reported to be passing medications and was behind in passing medications. Registered Nurse Employee E2 reported Registered Nurse Employee E1 did not request any assistance with CR1 and completed passing medications for a different resident. Registered Nurse Employee E2 then went to CR1's room but did not check the resident for a pulse or respirations, observed mottling, reported the resident's hands were cold, and went back to passing medications to other residents. Registered Nurse Employee E2 also reported three Nursing Assistants were assigned to the unit. On [DATE], at 1:40 p.m., the Nursing Home Administrator was made aware Immediate Jeopardy was called as the facility failed to ensure staff initiated CPR to an unresponsive resident. The Immediate Jeopardy template was provided at that time and a corrective action plan was requested. Attempted phone contact made [DATE], at 3:48 to Nursing Assistant Employee E3. Message left requesting a return call. No response received. During an interview on [DATE], at 3:53 p.m. Nursing Assistant Employee E4 reported beginning their shift at 7:00 p.m. on [DATE]. The Nursing Assistant did not remember any staff person calling out for assistance for an unresponsive resident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 5:54 p.m. an Immediate Action Plan was accepted with the following actions: Immediate Action: Cited resident R1 was not administered CPR, has passed away and is no longer in the facility. Residents: Whole house audit will be conducted by DON (Director of Nursing) or designee on code status availability in same location in Point Click Care (electronic health record) and code binders on units with POLST/orders/advanced directives to ensure they match. NHA or designee will conduct a 6 month lookback to determine if residents code status/advanced directives were honored. System Correction: Facility policy reviewed. All licensed staff will be re-educated on the need to start CPR timely per AHA (American Heart Association) and facility policy/guidelines. This education will be completed by DON or designee by [DATE] in person and via telephone calls, with any staff not reached receiving the education prior to their next shift. Monitoring: Audits of code status as well as code drills will be conducted by DON or designee of weekly x4 weeks then monthly x3 months to ensure code status is correct and available to staff and that licensed staff are following the AHA and facility policy/guidelines. Ongoing results will be submitted to center Quality Assurance and Performance Improvement committee. During an interview on [DATE], at 10:46 a.m. Physician Employee E5 reported Registered Nurse Employee E1 phoned twice on [DATE], once in the morning as CR1 was not feeling well and refused dialysis, and again in the afternoon as CR1 was nauseated and an order for Zofran was given. Physician Employee E5 reported at approximately 8:00 - 8:15 p.m. Registered Nurse Employee E1 phoned to report CR1 was mottled and unresponsive and did not report the resident had any trauma or rigor mortis. Physician Employee E5 reported CPR should have been initiated and a call to 911 should have been placed. During observations, facility provided documentation, and staff interviews on [DATE], at 3:15 p.m., the whole house audit of resident code status was updated in Point Click Care (facility's electronic medical record), the resident's records and in code binders on the units, the 6 month lookback period to determine if residents code status/advanced directives were honored, audit forms and code drill forms were created and to be implemented on [DATE], were completed, and Quality Assurance and Performance Improvement committee was notified. Policy on Emergency Procedure - Cardiopulmonary Resuscitation was updated to include locations where code status could be found and obvious signs of irreversible death completed. Forty-five percent of the staff were re-educated on the updated facility policy and AHA guidelines on CPR and location of code status for residents. (continued on next page)

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