STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365607	A. BUILDING _____ B. WING _____	10/09/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF PIQUA	**275 KIENLE DRIVE PIQUA, OH 45356**

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 **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on review of closed and current medical records, review of an Emergency Medical Squad (EMS) report, review of a facility Self-Reported Incident (SRI), review of a facility investigation, interviews with staff and the physician, review of the facility Emergency Management Policy Guidelines, the facility failed to timely initiate Cardiopulmonary Resuscitation (CPR) and timely contact Emergency Medical Services (EMS) for one resident (#5) who was a Full Code and was found unresponsive and without vital signs. Life threatening harm and death occurred when Resident #5 did not receive timely CPR or EMS and expired at the facility. This resulted in Immediate Jeopardy for one (#5) of four residents reviewed for change in condition and death in the facility. The facility identified 49 residents residing in the facility designated with a Full Code status. The total facility census was 72 residents. On [DATE] at 2:35 P.M., the Administrator, Director of Nursing (DON) and Regional Nurse #325 were notified Immediate Jeopardy began on [DATE] at 5:30 P.M., when Resident #5 was found unresponsive. Licensed Practical Nurse (LPN) #360 was informed by State tested Nursing Assistant (STNA) #350 that Resident #5 was unresponsive, and LPN #360 subsequently checked Resident #5 and found the resident to be without a pulse and other vital signs. STNA #350 requested LPN #380 respond to Resident #5's room and LPN #380 confirmed the resident was without vital signs as well; however, neither LPN #360 nor LPN #380 began CPR. STNA #350 provided post mortem care to Resident #5. Hospice Provider #450 was notified of Resident #5's death. The medical record was not reviewed to confirm the resident's code status. Registered Nurse (RN)# 390 was in the facility and upon hearing of Resident #5's death, instructed the LPNs to check the resident medical record to verify the resident's code status. When LPN #360 checked the chart, the resident was discovered to be a Full Code. LPN #360 obtained the crash cart and proceeded to Resident #5's room to initiate CPR and 911 was called. Upon the EMS arrival at the facility, CPR was being performed on Resident #5. Resident #5 was noted by EMS services to be cold to touch, dependent lividity and rigor mortis was beginning to set in. EMS did not initiate care due to obvious signs of death. Resident #5 expired in the facility. The Immediate Jeopardy was removed on [DATE] at 7:00 A.M., when the facility implemented the following corrective actions: · On [DATE] at 6:21 P.M., CPR was initiated on Resident #5. · On [DATE] at 9:30 P.M., an ad hoc Quality Assurance meeting with the Administrator, DON and attendance by the medical director via teleconference was held and the abatement plan was reviewed and accepted. · On [DATE] at 9:55 P.M., LPN #360 was identified as an employee of a staffing agency and was educated by the Administrator regarding the facility Emergency Management Policy Guidelines. · On [DATE] at 9:55 P.M., an all staff education was initiated by the Administrator on the Emergency Management Policy Guidelines which includes the process defining the roles and responsibilities of nursing staff involved in the care of patients in an emergent situation which include physician notification with change in condition. Staff was not to work an assignment until education was completed. · On [DATE], RN #390 began reviewing all current resident's medical records to validate physician orders [REDACTED]. The audit was completed by 10:00 P.M. · On [DATE] at 8:30 A.M., Human Resource Director (HRD) #305 started an audit of all nurse's personnel files to validate an active license and CPR certification with a completion time of 11:30 A.M. · On [DATE] at 10:45 A.M., an audit of the crash cart was conducted and revealed all items were present on the cart needed to perform CPR. · On [DATE], the Unit Managers reviewed and updated current resident's care plans and Kardex with current physician ordered codes status. The audit was completed by 2:10 P.M. · On [DATE], all new employees hired will receive education on the Emergency Management Policy Guidelines which includes the process defining the roles and responsibilities of nursing staff involved in the care of patients in an emergent situation by the Administrator and/or the DON. Additionally, the center will ensure agency staff receive education on the Emergency Management guidelines which included the process and defining the roles and responsibilities of nursing staff involved in the care of the patients in an emergent situation by the DON and or Unit Manager prior to working in the facility. · On [DATE], all staff will be educated on the Emergency Management Policy Guidelines which includes the process defining the roles and responsibilities of nursing staff involved in the care of a patient in an emergent situation by the Administrator or DON or designee prior to working. Staff unable to participate in education will be removed from the schedule until such education has been completed by the DON and or Unit Manager. · On [DATE], the DON or Administrator will begin monitoring code status through the morning interdisciplinary team meeting daily for the next 14 days, then Monday through Friday on an ongoing basis. Areas of deficiency will be submitted to the Quality Assurance Committee and corrected immediately. · On [DATE], the DON will begin completing follow-up after death audits on any death in the facility and the audit will be completed Monday through Friday for thirty days. The floor nurses will call the DON with any death in the facility. · On [DATE] at 7:00 A.M., agency Nurse #397 was educated on the facility Emergency Management Policy Guidelines by HRD #305, prior to working in the facility on her next shift, [DATE] at 7:00 A.M. · On [DATE], review of the follow-up after death audit performed on [DATE] and [DATE], revealed the facility performed emergency management as per their policy for Resident #10 and #30 who expired in the facility. These are the only two deaths that occurred since Resident #5 expired. · On [DATE], the facility identified three other residents (#10, #20, and #30) who had expired in the facility in the last 60 days. The medical records were reviewed for change in condition and death and no concerns were identified. Additionally, four random resident medical records (#31, #32, #33, and #34) were reviewed and physician orders [REDACTED]. · On [DATE] and [DATE], at various times, interviews with RN #320, #360 and LPN #315, and agency LPN #340, revealed the staff have received recent emergency management training in the last few weeks that has included what to do if you find a resident who is unresponsive and without signs of life, where code status is located, and the process to follow to ensure residents are receiving prompt emergent care. The staff were able to verbalize the proper procedure. · On [DATE], review of the facility staffing schedules from [DATE] to [DATE] and the Agency Orientation Check List and Training revealed agency RN #405 worked on [DATE], evening shift, and agency LPN #410 worked on [DATE], [DATE], and [DATE]. The facility had no documented evidence of agency RN #405 and agency LPN #410 as having received training on emergency management prior to them working on the floor at the facility as per the facility's corrective action plan. Although the Immediate Jeopardy was removed on [DATE] when the facility implemented the corrective action plan including

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365607	A. BUILDING _____ B. WING _____	10/09/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF PIQUA	275 KIENLE DRIVE PIQUA, OH 45356

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 **Residents Affected -** Few	(continued... from page 1) training agency staff on the facility's Emergency Management Policy Guidelines for initiating CPR on a resident with a Full Code status prior to working, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for minimal harm that is not Immediate Jeopardy) as the facility is still in the process of monitoring to ensure on-going compliance. Findings include: Review of Resident #5's closed medical record revealed an admission date of [DATE] and a re-admission date of [DATE]. Resident #5 had [DIAGNOSES REDACTED]. Review of the signed admission physician order [REDACTED]. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was cognitively intact, had no delusions, hallucinations or behaviors, was an extensive assist for bed mobility and eating but dependent on staff for all other daily care. The resident was coded as always incontinent of bowel and bladder, as being on a pain management program, as having a life expectancy of less than 6 months, and as receiving hospice services. Review of the advanced directive section of Resident #5's medical record revealed a green colored Full Code paper. The green paper documented the resident's name, FULL CODE and GO in bold letters. Also, under this section was the physician order [REDACTED]. Review of the (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of the task information document for STNAs revealed the documentation listed the resident as a Full Code. Review of Resident #5's care plan revealed the resident was receiving hospice services for End Stage ALS and as retaining a Full Code status. Review of Hospice admission paper work dated [DATE], revealed the resident was most recently enrolled in hospice benefits with the advanced directive noted as being none. Review of the nurse's progress notes revealed the medical record lacked documented evidence of the resident expiring or the circumstances surrounding the resident's death. Review of the EMS report dated [DATE] revealed the squad was dispatched on [DATE] at 6:22 P.M., were in route at 6:24 P.M. and on the scene at 6:27 P.M. The report revealed the squad was dispatched for a resident in [MEDICAL CONDITION] at a facility. The report revealed the resident was found lying supine in bed in bedroom, with staff performing CPR. Staff stated they found the patient not breathing approximately one-half hour ago. Further assessment revealed the patient to be cold to touch, dependent lividity, and rigor mortis beginning to set in. EMS did not initiate care due to obvious signs of death. The EMS gathered patient information and returned to the station. Review of the facility SRI with an initial submission date of [DATE] and a final close date of [DATE] regarding suspicion of neglect or mistreatment was reviewed. The SRI documented the incident involved an agency LPN #360 as the perpetrator and Resident #5 as the involved resident. The investigation revealed LPN #360 found Resident #5 unresponsive and without vital signs at 5:35 P.M. The SRI indicated the LPN notified the hospice provider and first emergency contact of Resident #5's death. LPN #360 was then informed of Resident #5 being a Full Code status, emergency medical treatment was initiated and 911 was called, without a time being given in the SRI. Resident #5 was pronounced deceased at 6:30 P.M. by the EMS squad. The SRI was substantiated by the facility. Review of the undated facility investigation revealed the facility confirmed Resident #5 was found at 5:35 P.M. on [DATE], without signs of life confirmed by two LPN's. The resident's code status was not verified by the facility until 6:10 P.M. and the resident was not provided any emergency management intervention at the time of death. The facility staff became aware of Resident #5 wishing to be a Full Code at 6:10 P.M., when the medical record was checked. The facility investigation revealed CPR was not initiated until 6:21 P.M. Resident #5's death was pronounced by the squad at 6:30 P.M. Interview on [DATE] at 10:15 A.M., with RN #390, verified she was in the building when Resident #5 expired. RN #390 stated it was approximately 6:10 P.M., when she became aware the resident had expired and she told the agency nurse to check the chart regarding Resident #5's code status. RN #390 stated LPN #360 checked the chart and stated Resident #5 is a Full Code. RN #390 told LPN #360 she needed to initiate CPR. RN #390 stated LPN #360 stated Even after this long? and RN #390 replied to her yes. RN #390 stated she called 911 and hospice and told the LPN to initiate the Full Code. Interview on [DATE] at 11:33 A.M., with Physician #500, verified she was the physician for Resident #5 and she did receive a call the evening of [DATE] that the resident was found pulseless and without respirations. Physician #500 stated she asked when the resident was last seen alive and was told 25 minutes prior Resident #5 was at her base line. Physician #500 denied the facility discussing the resident's code status with her at this time. The physician did confirm she was aware the resident was under the care of hospice for her End Stage ALS, and the resident s condition was declining. Physician #500 stated the facility called back later that evening to discuss the delay in CPR for Resident #5 and she participated in an ad hoc Quality Assurance meeting via phone about the education, monitoring auditing and the process of checking code status immediately when a resident expires. Interview on [DATE] at 11:34 A.M. with STNA #350, revealed she provided care to Resident #5 on [DATE] at 5:20 P.M., she then left the room and provided care to other residents. STNA #350 stated she returned to Resident #5's room approximately 10 to 15 minutes later and Resident #5 was deceased . The STNA stated Resident #5's color was darker and when she touched Resident #5 she was still warm but when she called her name there was no response when Resident #5 would have normally had a response. STNA #350 stated she yelled for the nurse who was right outside the door performing the medication pass. STNA #350 stated the nurse came in the room, checked for a pulse, used the stethoscope and stated she is deceased . The STNA stated she was going down the hall to get another nurse because that was the normal process when someone is deceased . STNA #350 stated LPN #380 came to the room and confirmed the resident was without signs of life. STNA #350 stated neither nurse talked about code status or about initiating CPR. The STNA stated she then went to provide care for another resident. STNA #350 stated she then completed post mortem care on Resident #5 and had left Resident #5's room when she saw the nurses with the crash cart go to Resident #5's room. STNA #350 confirmed she witnessed Resident #5 receiving CPR from the nurses at the facility after she had performed post mortem care. STNA #350 stated the squad did respond to the facility after the nurses began CPR. Interview on [DATE] at 3:21 P.M. with LPN #380 was attempted with no response and a message left to return the call. No return call was received. Interview on [DATE] at 3:24 P.M. with LPN #360 was attempted with no response and a message left to return the call. No return call was received. Interviews on [DATE] and [DATE], at various times, with RN #320, RN #360, LPN #315, and agency LPN #340, revealed the staff have received recent Emergency Management Training in the last few weeks that has included what to do if you find a resident who is unresponsive and without signs of life, where code status is located and the process to follow to ensure residents are receiving prompt emergent care. The staff were able to verbalize the procedure. Interview on [DATE] at 10:00 A.M. with HRD #305 revealed a request was made for the Agency Orientation Check List for LPN's #360, #370, and #340. HRD #305 provided the Agency Orientation Check List for LPN #360 and LPN #370 dated [DATE] and for LPN #340 dated [DATE]. Interview on [DATE] at 4:00 P.M., with the DON and Regional Nurse #325, revealed it is the company policy to examine the crash cart and audit employee files for CPR certification as part of the Emergency Management Review. The DON and Regional Nurse confirmed the staff had all needed supplies to provide Resident #5 with CPR on [DATE] and all staff were current in CPR certification. Review of Resident #10, #20 and #30's medical records on [DATE] revealed the residents expired at the facility and had do not resuscitate orders which the facility honored. Review of the facility staffing schedules from [DATE] to [DATE] and the Agency Orientation Check List and Training revealed LPN #410 worked on [DATE], [DATE], and [DATE]. The facility had no documented evidence of agency LPN #410 as having received Emergency Management Training prior to working on the floor as per the facility's corrective action plan. Interview on [DATE] at 5:24 P.M. with the Administrator and HRD #305, verified the facility had no documented evidence that LPN #410 received training on the facility policy of Emergency Management and had worked [DATE], [DATE] and [DATE]. Review of the Staff Development Program Attendance Record provided by the facility for documentation of staff who had attended the Emergency Management in-service revealed there have been nine RNs, 17 LPNs, and 18 STNAs trained to date. Review of the all staff listing provided by the facility revealed the facility employs nine RNs, 20 LPNs and 31 STNAs. Review of the policy titled Emergency Management with a date of [DATE] and a revision date of ,[DATE], revealed under the section titled Emergency Response Guidelines: the first licensed nurse that arrives on the scene will evaluate the patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365607	A. BUILDING _____ B. WING _____	**10/09/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF PIQUA	**275 KIENLE DRIVE PIQUA, OH 45356**

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 **Residents Affected -** Few	(continued... from page 2) level of consciousness, circulation, airway and breathing. The nurse directs additional licensed nurses to review chart for living will or do not resuscitate (DNR) documentation, physician orders [REDACTED]. The nurse directs additional responders to page emergency code per center established process, e.g. Code Blue, Code 100, paging Dr. Blue, etc. Page is repeated at least two times if resident is full code. The nurse directs additional license nurses or staff member to phone emergency medical services (EMS) team requesting emergency assistance. This deficiency substantiates Complaint Number OH 357.