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{F 000}	INITIAL COMMENTS The following citations represent the first non-complaince revisit for #LMTD12 and complaint investigation #123112.	{F 000}		
F 155 SS=F	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 155		

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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(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

483.24
(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 45 residents with 3 sampled for advance directives. Based on observation, interview and record review the facility failed to ensure staff who implemented cardiopulmonary resuscitation (CPR - emergency medical procedure for restoring normal heartbeat and breathing) continued the CPR until a physician ordered staff to stop or emergency medical services (EMS) assumed responsibility for 1 of 3 sampled residents (#1). The facility also failed to implement a clear and accurate system for staff to know and follow regarding residents' advance directives or code status with full code meaning to start cardiopulmonary resuscitation and Do Not Resuscitate meaning no CPR. This

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failure had the potential to affect all residents.

Findings included:

- The physician history and physical (H & P) signed 10/27/17 for resident #1 included the following diagnoses: acute coronary pulmonale (abnormal enlargement of the right side of the heart as a result of disease of the lungs), deep vein thrombosis (DVT- potentially life threatening blood clot, usually in the legs) of the lower extremity, hypertension (HTN- elevated blood pressure) and pulmonary embolism (a blockage in one of the pulmonary arteries in the lungs with most cases, caused by blood clot that traveled to the lungs from the legs). The H & P did not include information regarding the resident's code status/advance directives.

The entry minimum data set (MDS) dated 10/28/17 indicated the resident admitted to the facility on 10/28/17.

The admission care plan dated 10/28/17 did not include the resident's code status/advance directives.

The hospital Patient Transfer Summary (not signed by a physician) listed DNR (do not resuscitate/emergency medical procedure for restoring normal heartbeat and breathing) code status.

The hospital admission/transfer order form directed staff the resident would be discharged to the nursing home on a regular diet with orders to be non-weight bearing on the left lower extremity and follow-up with surgeon in 1 week. The orders did not include a code status.

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Review of the physician orders between 10/28/17 through 11/2/17 whether written, telephone order or fax revealed no orders related to the resident's code status/advance directives.

Review of the profile face sheet (paper form) within the chart revealed the resident had a durable power of attorney (DPOA- agent designated to make decisions for a resident in the event the resident became incapable) for health care but did not list any living will or code status. The electronic home page for the resident with their photo listed the resident as a Full code meaning staff should perform cardiopulmonary resuscitation (CPR - emergency medical procedures to restore normal heartbeat and respirations) should he/she stop breathing and lack a heartbeat.

The Living Will (advance directives that specify what to do if a resident stopped breathing and lacked a heartbeat) and DPOA papers signed 9/24/15. He/she directed all life prolonging procedures should be withheld or withdrawn when there was no hope of significant recovery and he/she had the following: a terminal condition, a condition, disease or injury without reasonable expectation he/she would regain an acceptable quality of life, or substantial brain damage or brain disease which cannot be significantly reversed. When any of the above conditions exist, He/she DID NOT WANT the life prolonging procedures which he/she initialed and treatments not initialed may be administered. He/she initialed beside all of these procedures indicating he/she did not want them when the above conditions existed (surgery, heart-lung resuscitation, antibiotics, dialysis, mechanical

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ventilator, tube feedings, other).

Review of the nursing notes revealed the following entries: on 10/28/17 at 6:06 PM the resident admitted to the facility at 3:05 PM with diagnoses of fractured left distal femur (thigh/leg bone), he/she was alert and oriented to person, place and time, denied pain or discomfort, weakness, dizziness, nausea or headache. He/she had a history of dementia (progressive mental disorder characterized by failing memory, confusion), HTN and chronic pain.

On 10/30/17 at 8:26 PM a family member reported concerns regarding the resident having hallucinations (sensing things while awake that appear to be real, but the mind created) of seeing spiders on the floor. The nurse sent a fax to notify the resident's physician of this concern and the DPOA requested a DNR order for the resident. As of 11/7/17, the record lacked a signed response from the physician).

On 10/31/17 at 2:55 AM the resident had increased confusion, hallucinations and agitation this night. The resident stated he/she was 50 years old, was in another town and it was time to get up to eat breakfast. He/she attempted to get up several times and ripped off the ace wraps on his/her leg. The nurse administered as needed (PRN) pain medication, redirected/repositioned the resident and staff checked on the resident throughout the night.

On 11/1/17 at 12:01 AM the resident was alert and oriented person and place, denied any complaints of pain or discomfort. He/she required extensive assistance of 2 staff with a gait belt and cueing to get out of bed to use the bedside

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commode.

On 11/2/17 at 7:13 PM the resident became unresponsive after being on commode at 6:03 PM. Staff called emergency medical services (EMS) and started CPR. At 6:05 PM licensed nurse D had reviewed the resident's paper medical record which he/she indicated as a No CPR healthcare directive. Nurse D notified administrative licensed nurse F and gave a copy of the healthcare directive to EMS upon arrival to the facility. Staff stopped the CPR at 6:05 PM. EMS confirmed asystole (a cardiac arrest heart rhythm in which there is no discernible electrical activity on the heart monitor) at 6:10 PM with no further treatment rendered. Staff sent a page to the resident's physician at that time and notified the DPOA at 6:12 PM of not being able to obtain vital signs (blood pressure, heartbeat or respirations). The DPOA said the resident was a DNR and nurse D explained CPR was given for 2-3 minutes prior to locating the healthcare directive which indicated No CPR. The facility received a call back from the on-call doctor at 6:50 PM with orders to release the resident's body to funeral home.

Review of the EMS run report revealed the emergency call came in on 11/2/17 at 6:03 PM. The dispatch call portion of the report revealed at 6:04 PM the resident was clammy, low breathing, non-responsive and was in full code. EMS and fire department (FD) dispatched at 6:05 PM. The units from the FD with paramedics were on the scene at 6:10 PM and a second team arrived 6:12 PM. The narrative portion of the report indicated EMS on arrival found the resident with a chief complaint of cardiac arrest. The nursing staff stated the resident had low oxygen levels

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prior to calling EMS, roughly 20 minutes prior. Nursing staff stated he/she was a DNR and nursing staff had already called the family and funeral home.

Observation on 11/7/17 of the resident's paper chart binder revealed next to his/her name on both the front cover and binding had a green star indicating CPR should be performed.

Interview on 11/7/17 at 9:32 AM with direct care staff B revealed he/she knew a resident's code status from the chart but he/she did not know where specifically to get the information. He/she would grab the chart and take it to the nurse. He/she did not know of any other visual indicators of a residents' code status for rapid response.

Interview on 11/7/17 at 10:08 AM with direct care staff C revealed he/she would have to look through the chart to know a resident's code status and indicated there was a form about it. He/she did not know of any other visual indicators of a residents' code status for rapid response.

Interview on 11/7/17 at 2:23 PM with direct care staff A revealed he/she had assisted the resident with direct care staff H from the bedside commode when the resident became unresponsive, his/her face was white with little purple spots and he/she sat the resident back onto the commode. Direct care staff A stayed with the resident while staff H went to get a nurse. Licensed nurse G responded and the 3 staff transferred the resident to the bed. He/she lowered the head of the bed and nurse G began CPR. Licensed nurse F came with the ambu-bag (a bag valve mask used for manual pulmonary

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resuscitation). Then licensed nurse D came and he/she said the resident did not want CPR. Licensed nurse G, nurse F and nurse D stopped CPR and waited for EMS which was not in the building yet but he/she could hear the siren. Direct care staff A reported the resident's code status is on the chart. He/she did not know of any other visual indicators of a residents' code status for rapid response.

Interview on 11/7/17 at 9:57 AM with licensed nurse E revealed he/she knew a resident's code states by the stars on the name plate of the chart. He/she said a green star meant perform CPR and a red star meant no CPR. He/she did not know of any identification at the room of a resident's code status. He/she reported the resident was a Full code due to the green star on the chart.

Interview on 11/7/17 at 1:24 PM with licensed nurse D revealed he/she was preparing to leave work on 11/2/17 at 6:03 PM when administrative nurse F asked him/her for help related to coding the resident. He/she reported finding the advance directive of the resident and went to the resident's room to notify the staff performing CPR of this document. He/she reported seeing EMS coming in the double doors as he/she went to the resident's room, discussed the advance directive with administrative nurse F and licensed nurse G who decided to stop CPR and EMS arrived during this interaction.

Interview on 11/7/17 at 2:07 PM and notarized statement by licensed nurse G revealed he/she responded first to the direct care staff's call for emergency assistance. He/she found the resident on the bedside commode being held up by direct care staff A and the resident could not hold

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him/herself upright. Nurse G and direct care staff A assisted the resident to the bed where nurse G could not locate a pulse at the resident's wrist or neck. He/she directed staff A to put the vital sign machine on the resident and it did not register any readings. Administrative licensed nurse F arrived and discussed the situation with nurse G and asked if the resident was a Full code. Nurse G responded he/she did not know and went to the resident's chart. He/she saw the pink sheet of the recapitulation of the physician's orders which indicated Full code. He/she reported not finding a living will or DNR document so he/she returned to the room and started CPR. Then nurse F returned with the crash cart (a cart of supplies needed during CPR). Licensed nurse D came and stated the resident did not want CPR two times, held up a document which the resident had initialed and signed so he/she stopped CPR. EMS arrived within the next 5 minutes.

Interview on 11/7/17 at 1:43 PM with administrative nurse F who was also the nurse on duty for the resident revealed he/she was summoned by licensed nurse G to the resident's room. The resident was in bed with labored respirations and direct care staff A reported the resident had a weak pulse. Licensed nurse G had went to check the chart for code status and upon return reported the resident was a full code. Administrative nurse F directed nurse G to start CPR, he/she called EMS, directed licensed nurse D to call the doctor and family. He/she and direct care staff H returned to the room with the crash cart. Licensed nurse D came to the room with the healthcare directives and said the resident did not want CPR. EMS was not in the room yet and he/she along with nurse G stopped CPR then EMS arrived about a minute later. His/her

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notarized statement include the above information as well as him/her checking the chart and noting a green sticker indicating Full code, the pink sheet of the physician's orders indicated Full code and a brief glance at the advance directive perceived by him/her to be a Full code. He/she reported an expectation for staff to follow the resident's wishes for advance directive, check the chart for the code status and begin CPR if not a DNR. He/she reported the facility's system for staff to know a resident's code status included stars on the chart by the resident's name meaning green for a Full code and red for DNR. Also at the room the name plate will be white if a Full code and mauve/red if DNR. He/she reported the resident had a white nameplate.

The facility's CPR/Emergency Medical Care policy dated 6/2014 directed staff: all residents found un-responsive with no pulse and no written Do Not Resuscitate (DNR) order on the chart were to be administered CPR. If unsure of DNR order, start CPR. If there was no DNR order, initiate CPR, direct another staff member to call 911 (EMS) and notify the physician while CPR continued until emergency responders arrive and assumed responsibility. If a DNR order was found subsequent to CPR initiation, call the physician to discontinue CPR. If emergency responders were present prior to reaching the physician, the responders would assume responsibility for the CPR. The resident code status would be identified through a visual indicator at the resident's room and on the resident charts.

The facility failed to ensure staff who implemented cardiopulmonary resuscitation continued the CPR until a physician ordered staff to stop or emergency medical services assumed

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F 155	Continued From page 10 responsibility for this resident #1. The facility also failed to implement a clear and accurate system for staff to know and follow regarding residents' advance directives or code status with full code meaning to start cardiopulmonary resuscitation and Do Not Resuscitate meaning no CPR. This failure had the potential to affect all residents.	F 155		