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HILLTOP LODGE HEALTH AND REHABILITATION CENTER	815 N INDEPENDENCE AVENUE BELOIT, KS 67420

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F 000	INITIAL COMMENTS	F 000		

The following citations are the result of partial extended survey and complaint investigation KS00184614, KS00184943, and KS00185002.

On the 01/08/24 at 01:26 PM the facility received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the immediacy for Resident (R)1.

At 11:08 AM on 12/30/23, staff entered R1's room and identified R1 was not breathing. Staff applied oxygen, but noted R1 had no vital signs at that time. The Registered Nurse on duty, Licensed Nurse (LN) G, called the emergency room (ER) at the local hospital and spoke with a physician who LN G referred to as R1's primary care physician (PCP). LN G reported she received instruction from the physician, Consultant GG, not to initiate any resuscitative measures as Consultant GG was coming to the facility to assess R1. Facility staff failed to provide CPR to R1, who had a full code status, and failed to activate Emergency Medical Services upon identification of the emergent situation. R1 died in the facility. The deficient practice placed R1, and all residents with a full code status, in immediate jeopardy.

The facility implemented the following corrective actions in the approved immediacy removal plan:
Reviewed policies and procedures related to code status.
100% Audit of code status completed in the facility 01/08/24.
Staff were re-educated on facility policies by 10:00 PM on 01/08/24 by the Director of Nursing or designee regarding the following: CPR (including immediate initiation when appropriate)

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 000	Continued From page 1 and Communication of Code Status. Any staff member that did not attend training on 01/08/24 was not permitted to work until training was complete. A Quality Assurance and Performance Improvement (QAPI) meeting in response to the immediacy was conducted which included the Medical Director. On 01/09/24, the above corrective actions were verified by an onsite inspection. After removal of the immediacy, the deficient practice remained at the scope and severity of a "G." The 2567 was sent electronically on 01/17/24	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 59 residents with three residents reviewed for abuse, neglect, and exploitation. Based on record review,	F 600		

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F 600	Continued From page 2	F 600		

observation, and interview, the facility failed to prevent resident-to-resident abuse when Resident (R) 2 was unwantedly kissed on her hand and her mouth by R3. This deficient practice placed R2 at risk for unwanted sexual advances, anxiety, and impaired psychosocial functioning.

Findings included:

- R2's Electronic Medical Record (EMR) documented R2 had diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) of the right dominant side, aphasia (condition with disordered or absent language function), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set (MDS)," dated 12/21/23, documented R2 was rarely or never understood and had short-term and long-term memory deficit. The MDS documented R2 had functional limitation in range of motion of her bilateral upper extremities and her bilateral lower extremities.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 09/28/23, documented R2 was unable to complete the Brief Interview for Mental Status (BIMS) exam, had impaired decision making and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The CAA documented R2 required assistance with all of her activities of daily living.

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The "Communication CAA," dated 09/28/23, documented R2 was rarely/never understood and was at risk for missed messages, isolation, and depression.

R2's "Care Plan," directed staff R2 was totally dependent on one to two staff assistance with all of her activities of daily living (ADL).

The "Facility Reported Incident Intake Form," documented on 01/03/23 at 11:40 AM, R3 approached R2 and touched R2's hand. R3 then kissed R2's hand and leaned in and kissed R2 on the mouth. R2 put her hand up to attempt to block the action. Certified Medication Aide (CMA) R and Dietary Staff (DS) BB immediately removed R3 from the situation. Staff initiated one on one observation with R3. Staff reassured R2 that she was safe, and she shook her head in understanding. Administrative Nurse E talked with R3 about what he did and R3 stated "I kissed her hand and then on the lips and told her I loved her." Administrative Nurse E educated R3 that this was inappropriate behavior. R3 had good understanding and no aggression.

CMA R's "Witness Statement," dated 01/03/23, documented R3 asked CMA R about R2 and then R3 walked over to R2 and started kissing her left hand. R3 then bent over R2 and gave R2 an openmouthed, long kiss. DS BB walked over to R3 and R3 stood up and took his hand and started rubbing R2's head, face and ear. CMA R stated she told R3 to stop and R3 walked out of the dining room. CMA R stated she reassured R2 this would not happen again and R2 seemed relieved.

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F 600	Continued From page 4 DS BB's "Witness Statement," dated 01/03/23, documented DS BB saw R3 walk over to R2 and R3 rubbed R2's arm and kissed the top of R2's head. DS BB told R3 to leave R2 alone. The statement recorded DS BB heard CMA R say, "She doesn't need you touching her." R3 said, "Okay," and left the dining room. On 01/09/23, former employee, Administrative Nurse E, stated after the incident she talked to R3 and educated him regarding the inappropriateness of his behavior with R2. Administrative Nurse E stated R3 appeared to understand. Administrative Nurse E stated R3 was placed on one to one with staff for the rest of the day. Administrative Nurse E stated, R3 was able to independently ambulate throughout the facility but normally only came out of his room for meals. Administrative Nurse E stated the other administrative nurse was supposed to update R3's "Care Plan" regarding the incident. The facility's "Freedom from Abuse, Neglect, and Exploitation Policy," revised 11/06/17, documented it is the facility's policy to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing the residents' right to be free from abuse, neglect, misappropriation of resident property and exploitation. The facility failed to prevent resident-to-resident abuse when R2 was unwantedly kissed on her hand and her mouth by R3. This deficient practice placed R2 at risk for unwanted sexual advances, anxiety, and impaired psychosocial functioning.	F 600		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 59 residents with nineteen cognitively impaired residents at risk for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to implement interventions to protect nineteen cognitively impaired residents during an investigation of resident-to-resident abuse which occurred when Resident (R) 3 unwantedly and inappropriately touched and kissed R2, a cognitively impaired resident unable to consent. This placed the nineteen cognitively impaired residents who were unable to consent to sexual affections at risk for sexual abuse and psychosocial impairment.

Findings included:

- R3's Electronic Medical Record (EMR)

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F 610	Continued From page 6	F 610		

documented R3 had diagnoses of traumatic brain injury (TBI- an injury to the brain caused by an external force), hypertension (high blood pressure), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Quarterly Minimum Data Set (MDS)," dated 12/07/23, documented R3 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS documented R3 was independent with his activities of daily living and walked throughout the facility with a cane.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 04/22/23, documented R3 had physical and verbal behavioral symptoms towards others and refusals of care. The CAA documented R3 had a mental health history with delusional behaviors and R3 believed that God supports his beliefs.

R3's "Care Plan," dated 05/23/23, directed staff when conflict arose, remove R3 to a calm safe environment and allow him to vent and share his feeling. Staff were to approach R3 in a gentle, friendly, unhurried manner. The plan documented identified triggers for R3 included when others invaded R3's privacy in his room and when he experienced rejection from others verbally, physically, or mentally. The care plan lacked an intervention to prevent R3 from unwantedly touching and kissing cognitively impaired residents.

The "Facility Reported Incident Intake Form," documented on 01/03/23 at 11:40 AM, R3 approached R2 and touched R2's hand. R3 then kissed R2's hand and leaned in and kissed R2 on

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F 610	Continued From page 7	F 610		

the mouth. R2 put her hand up to attempt to block the action. Certified Medication Aide (CMA) R and Dietary Staff (DS) BB immediately removed R3 from the situation. Staff initiated one on one observation with R3. Staff reassured R2 that she was safe, and she shook her head in understanding. Administrative Nurse E talked with R3 about what he did and R3 stated "I kissed her hand and then on the lips and told her I loved her." Administrative Nurse E educated R3 that this was inappropriate behavior. R3 had good understanding and no aggression.

CMA R's "Witness Statement," dated 01/03/23, documented R3 asked CMA R about R2 and then R3 walked over to R2 and started kissing her left hand. R3 then bent over R2 and gave R2 an openmouthed, long kiss. DS BB walked over to R3 and R3 stood up and took his hand and started rubbing R2's head, face and ear. CMA R stated she told R3 to stop and R3 walked out of the dining room. CMA R stated she reassured R2 this would not happen again and R2 seemed relieved.

DS BB's "Witness Statement," dated 01/03/23, documented DS BB saw R3 walk over to R2 and R3 rubbed R2's arm and kissed the top of R2's head. DS BB told R3 to leave R2 alone. The statement recorded DS BB heard CMA R say, "She doesn't need you touching her." R3 said, "Okay," and left the dining room.

On 01/09/23, former employee, Administrative Nurse E, stated after the incident she talked to R3 and educated him regarding the inappropriateness of his behavior with R2. Administrative Nurse E stated R3 appeared to understand. Administrative Nurse E stated R3

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F 610	Continued From page 8 was placed on one to one with staff for the rest of the day. Administrative Nurse E stated, R3 was able to independently ambulate throughout the facility but normally only came out of his room for meals. Administrative Nurse E stated the other administrative nurse was supposed to update R3's "Care Plan" regarding the incident. The facility's "Freedom from Abuse, Neglect, and Exploitation Policy," revised 11/06/17, documented it is the facility's policy to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing the residents' right to be free from abuse, neglect, misappropriation of resident property and exploitation. The facility failed to implement interventions to protect nineteen cognitively impaired residents at risk from being placed in a position to have unwanted touching and kissing during an investigation of resident-to-resident abuse This placed the nineteen cognitively impaired residents who were unable to consent to sexual affections at risk for sexual abuse and psychosocial impairment.	F 610		
F 678 SS=K	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §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 identified a census of 59 residents	F 678		

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F 678	Continued From page 9	F 678		

with 24 residents who elected a full code (term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest) status. Based on record review and interview, the facility failed to ensure staff provided cardiopulmonary resuscitation (CPR) to Resident (R) 1, who desired resuscitative measures as indicated by her full code status. At 11:08 AM on 12/30/23, staff entered R1's room and identified R1 was not breathing. Staff applied oxygen, but noted R1 had no vital signs at that time. The Registered Nurse on duty, LN G, called the emergency room (ER) at the local hospital and spoke with a physician who LN G referred to as R1's primary care physician (PCP). LN G reported she received instruction from the physician, Consultant GG, not to initiate any resuscitative measures as Consultant GG was coming to the facility to assess R1. Facility staff failed to provide CPR to R1, who had a full code status, and failed to activate Emergency Medical Services upon identification of the emergent situation. R1 died in the facility. The deficient practice placed R1, and all residents with a full code status, in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Wernicke's encephalopathy (degenerative brain disorder caused by the lack of vitamin B1), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

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F 678	Continued From page 10	F 678		

The "Quarterly Minimum Data Set (MDS)," dated 10/12/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated R1 was unable to complete the interview, however the MDS documented R1's short-term and long-term memory were intact. The MDS lacked any documentation regarding R1's activities of daily living (ADL) and the assistance and support R1 required.

The "Cognitive Loss Care Area Assessment (CAA)," dated 07/14/23, documented R1 had a BIMS score of three, which indicated severe cognitive impairment. The CAA documented R1 required assistance with ADLs. The CAA documented R1 was at risk for isolation, depression, and further cognitive decline.

The "Mood State CAA," dated 07/14/23, documented R1's depression score increased in total severity and R1 was at risk for further decline in mood, weight loss, and agitation.

R1's "Care Plan," dated 11/10/21, documented R1 was a full code, wanted full resuscitation (CPR), and R1's wishes would be honored. R1's "Care Plan" documented R1 required one to two staff assistance for all of her ADLs and was dependent on staff for meeting her emotional, intellectual, physical, and social needs.

The "Physician's Orders," tab of R1's EMR documented an order, dated 11/04/21, noting R1 was a full code.

The "Notes" tab of R1's EMR revealed the following:

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The "Nurse's Note" dated 12/30/23 at 10:03 AM documented upon initial assessment that morning at the beginning of the shift, R1 rested in bed without signs or symptoms of distress or discomfort. R1 took fluids well but made no effort to assist with holding the cup. R1 drank a large amount of fluids with staff assistance. A short time later, staff provided morning cares. Staff transferred R1 to the recliner, which she was opposed to, but staff encouraged her and explained that sitting upright would help to prevent drainage and coughing. Staff observed R1 numerous times and R1 displayed no respiratory distress or cough. The note further documented that up to the time of the note, R1 rested without signs and symptoms of discomfort in the recliner. R1 drank fluids well but had poor food intake.

The "Nurse's Note," dated 12/30/23, documented staff entered R1's room to provide cares at approximately 11:08 AM and noted R1 was not breathing. Staff immediately alerted other staff members and placed oxygen on R1. Staff assessed R1 for vital signs and brought the crash cart into R1's room. Staff observed mottling (blotchy, red-purplish marbling of the skin near the end of life caused by slow blood circulation) to R1's bilateral (both sides) lower extremities and upward into her abdomen. R1's hands were cool and her face was pale. LN G was present in the room and called the ER and spoke to an ER nurse who informed LN G the physician, Consultant GG, was present at the desk. After notification, Consultant GG ordered staff not to initiate any procedures as she planned to go to the facility. Consultant GG arrived at the facility three to five minutes later and directed staff not to initiate CPR.

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The "Authorization to Release and Embalm," dated 12/20/23, documented R1 expired on 12/30/23 at 11:00 AM.

In Certified Nurse Aide (CNA) M's undated "Witness Statement," CNA M noted at approximately 11:00 AM she and two nurses ran into R1's room. Upon entering, staff presumed R1 dead. She stated LN G commented "This is a blessing" and expressed that R1 was a full code but CPR was not performed because R1 constantly expressed that she was in a lot of pain and LN G stated again that it was a blessing. Staff brought the crash carts into R1's room, but nothing was done. The statement documented LN G told everyone to make it look like they did something. CNA M stated after about ten minutes of being in R1's room, LN G checked for heart sounds and stated R1 had no heart sounds and went on the say she already knew that. CNA M documented LN G then tossed a mouth-to-mouth resuscitation pack to LN H and jokingly told LN H she could start CPR and mouth-to-mouth resuscitation. LN G took the pack back and stated she was just joking. CNA M s documented LN H stated LN G was the one "driving the train." While CNA M performed postmortem (after death) care with another CNA, LN H came back into the room. CNA M documented she told LN H that R1's body was still warm, and CPR should have been done since R1 was a full code. CNA M documented LN H responded that she thought that herself, but Consultant GG said to stop everything they were doing. CNA M documented she told LN H that they did not do anything to begin with.

In CNA N's "Witness Statement" dated 12/30/23,

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CNA N documented she came into work on the North Hall and received report that R1 was coughing and had a slight fever throughout the night. She stated LN H asked her and another CNA to get R1 into her recliner. About thirty minutes later, she and the other CNA performed morning cares for R1, dressed her, and got her up with the full lift. CNA N documented R1 complained of shortness of breath and kept saying "help me." Once R1 was in the recliner, she did not sound as raspy and harsh and she no longer complained of shortness of breath, but she breathed heavily. CNA N documented she gave R1 the call light and asked if R1 felt better, and R1 stated she did feel a little bit better. After leaving R1's room, CNA N reported R1's breathing situation to LN H. After everyone was up for lunch, CNA N asked LN H if it would be okay to lay R1 down before lunch. LN H said yes and instructed CNA N to elevate R1's head a bit more. CNA N documented she and another CNA entered R1's room and noticed R1 was white and purple. CNA N checked R1's pulse at her neck and wrist and there was no pulse. CNA N notified LN H that R1 was not breathing. CNA N and LN H reviewed the code list by the nurse's station and identified R1 was a full code. LN H ran to R1's room while CNA N retrieved the crash cart. CNA N documented she took the crash cart to R1's room and LN G was with her. She stated LN G put the oxygen mask on R1 and said she needed the Ambu-bag (handheld tool that is used to deliver positive pressure ventilation to any subject with insufficient or ineffective breaths). CNA N retrieved the South hall's crash cart. and returned to R1's room accompanied by CNA O. CNA M documented LN G was on the phone when she entered the room. LN G looked on the South crash cart for an Ambu-bag while LN H held the

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oxygen mask on R1. LN G stated the facility did not have an Ambu-bag and said the doctor said to stop, they were "done." CNA N stated she walked out of R1's room and did not return.

In CNA O's "Witness Statement" dated 12/30/23, CNA O documented she and CNA N ran to R1's room with the crash cart. LN H had the breathing mask on R1, and LN G was on the phone with the doctor. CNA O documented when LN G got off the phone, she directed staff not to start compressions on R1 as the doctor was on the way. LN H and LN G took the oxygen mask off R1. CNA O documented the doctor showed up and CNA O went back to the South hall.

LN H's "Witness Statement" dated 12/30/23, documented staff entered R1's room at approximately 11:08 AM to provide cares and noted R1 was not breathing. CNA N immediately alerted other staff members, who went to R1's room. Staff started R1 on oxygen and checked R1 for vital signs. LN H documented she was unable to obtain a pulse or blood pressure reading for R1. Staff brought the crash cart to the room. LN H documented R1 had mottling to her bilateral lower extremities and upward into her abdomen. R1's hands were cool, and her face was pale and white. LN H documented LN G was present and called the ER and spoke with the ER nurse. The ER nurse told LN G that the doctor was right next to her, and the ER nurse relayed the information to the doctor. LN H documented that the doctor directed LN G not to start resuscitative measures and the doctor was coming over to the facility. LN H documented Consultant GG arrived to R1's room right away and directed staff not to initiate anything.

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LN G's "Witness Statement," dated 12/30/23, documented LN H called the phone at the South nurse's desk at approximately 11:08 AM and asked LN G to "come quick." LN G documented she ran down the hall and observed CNA N pushing the crash cart down to the north hall. LN G documented she arrived in R1's room and saw R1 in the recliner. CNA N was sent after the South crash cart due to the fact the North crash cart had inadequate equipment. LN G documented she called the ER while LN H placed oxygen on R1. LN G documented the call to the ER was made from her personal cell phone at 11:09AM. LN G documented R1 was a blue dusky color and had absent pulse and respirations; R1 had mottling from her feet to her upper chest, and was cool to touch. LN G spoke to the ER nurse and told her that R1 was found with no pulse, dusky color, and cool skin with mottling from feet to the upper abdomen. LN G told the ER nurse she was not sure how long R1 had been deceased. LN G documented the ER nurse sat directly next to R1's primary care physician (PCP) and further documented staff were told "not to start anything" and R1's PCP would be right over. LN G documented she was uncertain of the exact time the physician arrived at the facility, but it was fairly directly after the phone call. LN G documented she made a sarcastic comment to LN H that LN H could start "mouth to mouth" because of the lack of equipment on the crash cart. LN G stated neither crash cart had an Ambu- bag or suction set up. LN G documented Consultant GG entered the room and listened to R1 with her stethoscope then pronounced R1 dead.

On 01/08/23 at 09:30 AM, LN H stated staff had not performed CPR on R1 because the physician

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said not to. LN H stated that CNA M was very upset about not performing CPR on R1 and called the police. LN H stated that she received education about performing CPR on residents with full code status immediately if found without pulse or respirations.

On 01/08/23 at 10:15 AM, CNA M stated that she was shocked when R1 was found without a pulse and respirations and the staff did not perform CPR. CNA M stated R1 still had quality of life and the staff owed it to her to honor her wishes to have CPR performed to try to save her life. CNA M stated that she voiced her concerns to LN H and LN H stated she agreed that CPR should have been performed on R1. CNA M stated she called the police to report the lack of action and the police came to the facility and took her statement.

On 01/08/23 at 10:45 AM, Consultant GG stated that she was not R1's primary care physician. Consultant GG stated she was the on-call coroner (an official who investigates violent, sudden, or suspicious deaths) on 12/30/23. Consultant GG stated she was sitting in the emergency room when LN G called and spoke to the ER nurse about the situation with R1. Consultant GG stated that she never told the facility not to start CPR or to stop anything that they had already initiated. Consultant GG stated she told staff she would be over to the facility to pronounce R1's death. Consultant GG stated that she recorded 11:00 AM as the time of death.

On 01/08/23 at 12:30 PM, Administrative Nurse D stated CPR should have been initiated on R1 immediately by the staff on 12/30/23 when they identified R1 was pulseless and without

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respiration while other staff called 911, R1's primary care physician, and R1's family.

The facility's "Cardiopulmonary Resuscitation Policy," dated 09/09/20, documented it is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance with these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR). The facility will follow current AHA guidelines regarding CPR. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to arrival of the emergency medical services; and in accordance with the residents advanced directives; or in the absence of advanced directives or a DNR order; and if the resident does not show obvious signs of clinical death (e.g., rigor mortis [recognizable signs of death, characterized by stiffening of the limbs], dependent lividity [gravitational pooling of blood to lower dependent areas resulting in a red/purple coloration], decapitation [removal of the head], transection [cut in half], or decomposition [decay of the body]).

The facility staff failed to provide CPR to R1, who had a full code status, and failed to activate Emergency Medical Services upon identifications of the emergent situation. R1 died in the facility. The deficient practice placed R1, and all residents with a full code status, in immediate jeopardy.

The facility implemented the following corrective actions in the approved immediacy removal plan:
1. Reviewed policies and procedures related to code status.
2. 100% Audit of code status completed in the

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F 678	Continued From page 18 facility 01/08/24. 3. Staff were re-educated on facility policies by 10:00 PM on 01/08/24 by the Director of Nursing or designee regarding the following: CPR (including immediate initiation when appropriate) and Communication of Code Status. 4. Any staff member that did not attend training on 01/08/24 was not permitted to work until training was complete. 5. A Quality Assurance and Performance Improvement (QAPI) meeting in response to the immediacy was conducted which included the Medical Director. On 01/09/24, the above corrective actions were verified by an onsite inspection. After removal of the immediacy, the deficient practice remained at the scope and severity of a "G."	F 678		