STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75VT	A. BUILDING: _____ B. WING _____	C 06/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE C	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS #15969, from 06/17/19 through 06/21/19. The SA substantiated the complaint that Resident #1 did not have Cardiopulmonary Resuscitation (CPR) done per the instructions in his Advance Directive, physician's order and care plan. During the survey, it was determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M500. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 6/19/19 at 12:20 PM, which began on 6/2/19, when the facility failed to honor Resident #1's Advance Directive, failed to implement the Care Plan for CPR, and failed to perform CPR when Resident #1 was found without a pulse and without respirations. Resident #1 expired at the facility. The facility's failure to honor the full code order, Advance Directive, and follow the care plan to perform CPR, when Resident #1 was found unresponsive, without pulse or respirations, placed this resident and other resident's with the Advance Directive, care plan and order for CPR, in a situation that was likely to cause serious injury, harm, impairment, or death. The facility's Administrator was notified of the Immediate Jeopardy and SQC, and provided a copy of the Immediate Jeopardy template, on 6/19/19 at 12:20 PM. IJ existed at: M500-Resident Rights The Facility submitted a credible removal plan on 6/20/19, in which the facility alleged all corrective	M 000		

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M 000	Continued From page 1 actions to remove the IJ was completed on 6/5/19, and the IJ removed on 6/6/19. The SA validated the facility's removal plan prior to exit, and determined the IJ was removed as of 06/06/19, based on completion of all activities to remove the IJ as of 06/05/19. Therefore, the scope and severity for M500-Resident Rights, was lowered to a "Level II", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility will remain out of compliance related to deficiencies on the annual re-certification survey of 4/22/19, and complaint survey of 5/9/19. The facility had a license for 120 beds, with a census of 98.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility,	M 500		6/25/19

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M 500	Continued From page 2	M 500		

and of related charges including any charges for services covered by the facility's basic per diem rate;

3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care

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M 500	Continued From page 3	M 500		

established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

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M 500	Continued From page 4 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent	M 500		

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M 500	Continued From page 5 personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on record review, staff interview, and facility policy review, the facility failed to perform Cardio-Pulmonary Resuscitation (CPR) for Resident #1, who had an Advance Directive, an order, and care plan for a full code. This was for one (1) of six (6) residents reviewed. Resident #1 expired in the facility. Resident #1 had an Advance Directive, an order and a care plan for CPR, and the facility failed to perform CPR when Resident #1 was found without a pulse and without respirations, on 6/2/19. The facility's failure to honor the Advance Directive, physician's order, and care plan to perform CPR, on 6/2/19, when Resident #1 was found unresponsive, without pulse or respirations, placed this resident and other residents with Advance Directives, orders and care plans for a full code, in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 6/2/19, when the facility failed to honor Resident #1's Advance Directive, physician's order, and care plan, to perform CPR, when Resident #1 was found without a pulse and without respirations. The facility's Administrator was notified on 6/19/19 at 12:20 PM, of the Immediate Jeopardy, and provided a removal plan, in which the facility alleged all corrective actions were completed on 6/5/19, and the IJ removed as of 6/6/19.	M 500	1. License Practical Nurse (LPN) #1, LPN#2, and Respiratory Therapy (RT) #1 was suspended on 6/3/2019, by Administrator for failing to initiate Cardiopulmonary Resuscitation (CPR) on a resident with a Full Code status. LPN#2 and RT#1 received disciplinary action due to failure to verify the code status upon notification by LPN#1, and 1:1 in services was conducted by Administrator and Respiratory Therapy Director to LPN#2, and RT#1 on verification of code status, following code status, and documentation of code status on 6/5/2019, prior to providing care. On 6/5/2019, LPN #2, and RT #1 were returned to work as scheduled. LPN #1 was termed and reported to BON on 6/5/2019, by Director of Nursing (DON). 2. Residents with the Advance Directive of full code status had the potential to be affected by the deficient practice. On 6/3/2019, an audit was conducted by Medical Records on all current residents to ensure orders are in place for Code Status/ Advance Directives for code status and following the care plan, comparing the chart, advance directives, and Kardex. This was completed on 6/3/2019, by Medical Records with no negative findings. On 6/3/2019, an audit was conducted by Medical Records on all residents that expired in the facility over the past 3 months to ensure code status	

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M 500	Continued From page 6 The SA validated the facility's removal plan and determined the IJ was removed on 6/6/19, prior to exit on 6/21/19. Therefore, the scope and severity of CFR(s): 483.24 (a)(3); Cardio-pulmonary Resuscitation (CPR)-M 0500, was lowered to a "D" level, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility Policy entitled, "CPR Policy", revised 07/18/18, revealed, "1. In the event of cardiopulmonary arrest of a resident/patient without DNR (Do Not Resuscitate) status, life support measures will be initiated". Also, "C. Nurses Responding: Establish a patent airway, c. Begin CPR (Cardiopulmonary Resuscitation)". Review of the "Admission Record" revealed the facility re-admitted Resident #1 on 11/19/18, with diagnoses which included Dementia and Seizures. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/30/19, revealed he scored 11 of 15 on the Brief Interview for Mental Status which indicated Resident #1 had moderately impaired cognitive abilities. Review of the "Resident/Family Consent for Cardiopulmonary Resuscitation", dated 03/04/16, revealed Resident #1 was a "Full Code". The "Order Summary", active orders as of April 1, 2019, also confirmed Resident #1 should have received CPR. Review of a facility investigation, dated 6/5/19,	M 500	was followed, advance directives matched the code status order, and the care plan matched the code status and advance directives with no negative findings. This was completed by Medical Records on 6/3/2019. 3. On 6/3/2019, the Administrator met with Hospice Company to change the wording on hospice charts from , Don□t call 911, call Hospice, to Notify Hospice with any change of condition, so there would be no misinterpretation of instructions. On 6/3/2019, An Ad HOC Quality Assurance Performance Improvement (QAPI) meeting was held for failure to follow code status with an order for Cardiopulmonary Resuscitation (CPR) with the Interdisciplinary team, including but not limited to, Medical Director, Administrator, Respiratory Therapy Director, Medical Records, Social Services Director, Minimum Data Set (MDS), Director of Nurses (DON), Assistant Business Office Manager (ABOM), and Business Office Manager (BOM). The results of the audits conducted by Medical Records were reviewed during this Quality Assurance Performance Improvement (QAPI) meeting. The facility Cardiopulmonary Resuscitation (CPR) Policy and No Code Policy were reviewed with no changes. The facility implemented the following systems, as discussed in Ad HOC Quality Assurance Performance Improvement (QAPI) to ensure ongoing compliance on 6/3/2019. System A: Color door tags of red(Do Not Resuscitate) and green (Full Code) are utilized to identify code status for all residents, new residents door tags	

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M 500	Continued From page 7 revealed that Resident #1 was found without pulse and respiration on 6/2/19, at approximately 10:00 PM. The report documented that CPR was not performed on Resident #1. A written statement, documented by LPN #2, dated 6/3/19, revealed he thought Resident #1 was a DNR. Review of a written statement, dated 6/3/19, by LPN #3, revealed that she walked to the nurse's station on 6/2/19 at 10:30 PM, and was told by LPN #2 that Resident #1 was found deceased at 10:00 PM. LPN #3 documented that she checked the resident's chart and found that he was a full code. LPN #3 documented that she approached LPN #2 and asked if CPR was initiated, and the LPN responded that it wasn't, because he thought Resident #1 was a DNR, and did not check the chart. Review of the "Progress Notes", dated 06/02/19 at 10:25 PM, by LPN #2, revealed Resident #1 was found not breathing around 10:00 PM. The note documented the resident was a DNR. There was no indication he had checked the Resident's Advance Directive, orders, or care plan, and CPR was not initiated. The progress note documented that Resident #1's stomach and neck were warm to touch. Review of the progress note dated 06/03/19 at 12:39 AM, by Respiratory Therapist (RT) #1, revealed LPN #1 stated the resident had passed and she was calling hospice. The RT documented that LPN #1 confirmed a DNR status. There was no documentation that CPR was initiated. Interview on 06/18/19 at 12:25 PM, with LPN #2 (primary nurse) confirmed he had not checked Resident #1's code status (CPR/full code or DNR/no code). He also stated the error had been	M 500	are applied upon admission or with advance directive change after verification of signed advance directive and Medical Director/Physician order by Medical Records. System B: Audit of all new admissions, advance directives and code status system review to include code status order, advance directive, care plan and kardex, Physician progress note and color coded door tag to ensure there are no discrepancies by Medical Records. On 6/3/2019, the direct care staff was in serviced by Administrator, Director of Nurses (DON), and Assistant Director of Nurses (ADON), Corporate Clinical Specialist (CCS), Staff Development Coordinator (SDC), Medical Records and Respiratory Therapy on where code status is located in the chart, electronic medical record and the color coded door tags. 4. Beginning weekly on 6/5/2019, for four (4) weeks, then Monthly x 2 months, an audit will be conducted by Medical Records on all new admissions to ensure orders are in place for Code Status/ Advance Directives for code status and following the care plan, comparing the chart, advance directives, Kardex, and door tag to ensure code status accuracy and compliance . Any negative concerns will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning weekly on 6/5/2019, for four (4) weeks, then Monthly x 2 months, an audit will be conducted by Medical Records on all residents that expire in the facility to ensure code status is followed, advance directives matched the code status order, and the care plan	

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M 500	Continued From page 8 noticed later, when LPN #3 was looking at Resident #1's chart after the staff from hospice had arrived at the facility (approximately 20-30 minutes later). LPN #2 stated that CPR would have been unsuccessful, due to the amount of time which had lapsed between the discovery of Resident #1 and the discovery of his full code status. Interview, on 06/18/19 at 12:50 PM, with LPN #1, confirmed she had attempted to locate the code status for Resident #1, but had been unable to locate the information in the electronic chart. She knew the Resident received hospice, and thought all residents who received hospice benefits had a DNR status. LPN #1 confirmed she did not start CPR on Resident #1. Interview, on 06/20/19 at 11:11 AM, with Respiratory Therapist (RT) #1 revealed that LPN #1 informed her Resident #1 had died, and said she was going to call hospice. RT #1 then found LPN #2, providing care in another resident's room, and informed him Resident #1 was deceased. RT #1 also stated she had never not performed CPR on anyone who was a full code, but she had been told the Resident was a no code by LPN #1. RT #1 stated that she did not check the chart to confirm what she had been told. RT #1 stated there had been nothing in the room to indicate the Resident had a full code order, and she had not been aware he had requested CPR (cardiopulmonary resuscitation). Interview, on 06/20/19 at 3:15 PM, with the facility's Medical Director, revealed he had been informed Resident #1 had not received CPR per his Advance Directive, the morning after the error had occurred. He also stated he expected all staff to follow the orders in the residents' clinical	M 500	matched the code status and advance directives and the door tag matches the correct code status. Any negative concerns will be immediately reported to the Administrator or Director of Nursing for further intervention and is submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	

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M 500	Continued From page 9	M 500		

records.

The facility submitted an acceptable Removal Plan on 06/20/19, for the Immediate Jeopardy. Review of the Removal Plan revealed the facility took the following corrective measures:

Brief Summary
1. The facility failed to perform Cardiopulmonary Resuscitation (CPR) on a Resident with an Advance Directive for a full code. On 06/02/2019, at approximately 10:00 PM, Resident #1 was found unresponsive by Certified Nursing Assistant (CNA) #1. CNA #1 yelled to Licensed Practical Nurse (LPN) #1 to come to the room. LPN #1 evaluated resident as non-responsive with cold wrists to touch and skin greyish in color. LPN #1 yelled for Respiratory Therapy. Respiratory Therapy (RT) #1 heard yelling and approached LPN #1, who informed RT #1 of Resident #1's health status, that Resident #1 was receiving hospice and had a Do Not Resuscitate (DNR) status. LPN #1 went to the nurses' station to call hospice because the resident was deceased and LPN #1 thought the Resident was a DNR. LPN #1 reviewed Resident #1's chart and did not verify code status. RT #1 assessed Resident #1 and found the resident to have cold arms, face and head with a warm torso and without respirations. RT #1 went to LPN #2, who was Resident #1's assigned nurse, and informed LPN #2 that the resident had expired, and LPN#1 had stated he was a DNR on hospice. On 06/02/19, at approximately 10:30 PM, LPN #3 informed LPN #1 and LPN #2 of resident being a full code. At this point the Resident's family and the hospice Chaplin were in the room, and LPN #2 stated at this point it was too late to initiate CPR. LPN #1 exited facility at approximately 10:30 PM. The Administrator was notified, on 06/03/19 at

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M 500	Continued From page 10 approximately 12:00 AM, by LPN #3, that Resident #1 had expired and did not receive CPR. Corrective Action 1. On 06/03/19, at approximately 8:00 AM, LPN #1, LPN #2 and RT #1 were suspended, pending further investigation for failing to initiate CPR on a resident with full code status. 2. The unusual occurrence investigation was initiated by the facility Administrator, on 06/03/19 at approximately 8:00 AM, for failure to verify the code status and initiate the Resident's Advanced Directive. 3. The following individuals were notified of the failure to follow the Advance Directive for a resident with a full code status on 06/03/19: Responsible Party at approximately 5:00 PM, Attending Physician at approximately 4:00 PM, Medical Director at approximately 1:00 PM, Department of Health at approximately 6:30 PM, and the Mississippi State Attorney General (AG) Office was notified at approximately 6:30 PM, of failure to follow the Advance Directive for a resident with a full code status. 4. On 06/05/19, prior to providing care, LPN #2 and RT #1 received disciplinary action due to failure to verify the code status upon notification by LPN #1, and a one on one (1:1) in-service was conducted by the Administrator and the Respiratory Therapy Director to LPN #2 and RT #1, on verification of code status, following code status, and documentation of code status on 06/05/19, prior to providing care. On 06/05/19, LPN #2 and RT #2 were returned to work as scheduled.	M 500		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 11 5. LPN #1 was terminated at the conclusion of the investigation for failing to verify code status and initiate CPR on 06/05/19. However, LPN #1 did not return to the facility to sign the disciplinary action until June 10, 2019. LPN #1 was reported to the Board of Nursing, by the Director of Nursing (DON), on 06/05/19, at 3:50 PM, for failure verify the code status and initiate CPR. 6. On 06/03/19, beginning at approximately 8:00 AM, the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC) and Assistant Director of Nursing (ADON) initiated education with all direct care staff on Code Status verification and identification by instructing on how to find the code status in the record, on Electronic Medical Record (EMR), on the Kardex, and the resident's Medical Record, by having direct care staff complete a return demonstration on how to identify a resident's code status on the EMR, and following the Advance Directive Care Plan. No direct care staff are to return to work without completing required education. 7. On 06/03/19, beginning at approximately 8:00 AM, Medical Records began conducting a 100 percent (%) audit of Residents to ensure orders were in place for code status/Advance Directive and following the Care Plan, comparing the chart, Advance Directive and Kardex. The audit was completed on 06/03/19, at approximately 2:00 PM by Medical Records, with no negative findings. 8. On 06/03/19, at 8:00 AM, an audit was conducted by Medical Records on all residents who expired in the facility over the past three (3) months to ensure the code status was followed, Advanced Directives matched the code status orders, and that the Care Plan matched the code status and Advanced Directive, with no negative	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75VT	A. BUILDING: _____ B. WING _____	C 06/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 500	Continued From page 12 findings. The audit was completed by Medical Records on 06/03/19, by approximately 2:00 PM. 9. On 06/03/19, the Administrator met with the Hospice Company at approximately 2:30 PM, to change the wording on hospice charts from "Don't call 911, call hospice" to "Notify Hospice with any change of condition", so there would be no misinterpretation of instructions. 10. On 06/03/19, at approximately 3:00 PM, an Ad HOC Quality Assurance Performance Improvement (QAPI) meeting was held for failure to follow code status with an order for CPR with the Interdisciplinary Team, including but not limited to the Medical Director, Administrator, Respiratory Therapy Director, Medical Records, Social Director, Minimum Data Set (MDS) Coordinator, DON, Assistant Business Office Manager, and Business Office Manager. The results of the audits conducted by Medical Records were reviewed during the QAPI meeting. The facility CPR Policy and No Code Policy were reviewed with no changes. The facility implemented the following systems, as discussed in Ad HOC QAPI, to ensure ongoing compliance on 06/03/19: a. Audit of all new admissions Advance Directive and code status system review to include code status order, Advance Directive, Care Plan and Kardex, MD Progress Note and color coded door tags, b. Colored door tags of red (DNR) and green (Full Code) are utilized to help identify code status for all residents, new residents door tag are applied upon admission or with an Advance Directive change, after verification to signed Advance Directive and Physician's order by Medical Records.	M 500		

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M 500	Continued From page 13 11. On 06/03/19, at approximately 3:30 PM, the direct care staff was in-serviced by the Administrator, DON, ADON, Corporate Nurse Specialist, SDC, Medical Records, and RT on the color coded door tags, implemented on 06/03/19, to assist the direct care staff in identifying the resident code status, red (DNR) and green (Full Code). The facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 06/05/19, and the Immediate Jeopardy was removed 06/06/19. The SA validated the facility's Removal Plan on 06/21/19, by interview, observation, and record review, and determined the facility took the following actions to remove the IJ: Brief Summary 1. The SA validated that the facility failed to perform Cardiopulmonary Resuscitation (CPR) on Resident #1, who had an Advance Directive, care plan, and order for a full code, on 06/02/2019, at approximately 10:00 PM, when the Resident was found unresponsive and without pulse and respirations. Corrective Action 1. The SA validated by interview and record review, that on 06/03/19, LPN #1, LPN #2, and RT #1 were suspended pending further investigation for failing to initiate CPR on a resident with full code status. 2. The SA validated through interview and record review, that an investigation was initiated by the facility Administrator, on 06/03/19, for failure to verify the code status and initiate the	M 500		

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M 500	Continued From page 14 Resident's Advanced Directive. 3. The SA validated through interview and record review that the Responsible Party, Attending Physician, Medical Director, Department of Health, the Mississippi State Attorney General (AG) Office was notified of the failure to follow the Advance Directive for a resident with a full code status. 4. The SA validated through interview and record review that on 06/05/19, prior to providing care, LPN #2 and RT #1 received disciplinary action due to failure to verify the code status upon notification by LPN #1, and a 1:1 in-service was conducted by the Administrator and the Respiratory Therapy Director to LPN #2 and RT #1, on verification of code status, following code status and documentation of code status on 06/05/19, prior to providing care. 5. The SA validated through record review and interview that LPN #1 was terminated at the conclusion of the investigation for failing to verify code status and initiate CPR on 06/05/19, and that LPN #1 was reported to the Board of Nursing, by the Director of Nursing (DON), on 06/05/19, for failure verify the code status and initiate CPR. 6. The SA validated through interview and record review that on 06/03/19, the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC) and Assistant Director of Nursing (ADON) initiated education with all direct care staff on Code Status verification and identification by instructing on how to find the code status in the record, on Electronic Medical Record (EMR), on the Kardex, and the resident's Medical Record, by having direct care staff	M 500		

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M 500	Continued From page 15	M 500		

complete a return demonstration on how to identify a residents code status on the EMR, and following the Advance Directive Care Plan. Through interview and review of the facility staff roster, the SA verified that no direct care staff returned to work without completing required education.

7. The SA validated through interview and review of the documented audits, that on 06/03/19, Medical Records conducted a 100% audit of Residents to ensure orders were in place for code status/Advance Directive and following the Care Plan, comparing the chart, Advance Directive and Kardex, with no negative findings.

8. The SA validated through record review and interview that on 06/03/19, an audit was conducted by Medical Records on all residents who expired in the facility over the past three (3) months to ensure the code status was followed, Advanced Directives matched the code status orders, and that the Care Plan matched the code status and Advanced Directive, with no negative findings.

9. The SA validated through record review and interview, that on 06/03/19, the Administrator met with the Hospice Company and the hospice charts were observed to have "Notify Hospice with any change of condition", so there would be no misinterpretation of instructions.

10. The SA validated through interview and sign-in sheets, that on 06/03/19, an Ad HOC Quality Assurance Performance Improvement (QAPI) meeting was held for failure to follow code status with an order for CPR with the Interdisciplinary Team, including but not limited to the Medical Director, Administrator, Respiratory

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M 500	Continued From page 16 Therapy Director, Medical Records, Social Director, Minimum Data Set (MDS) Coordinator, DON, Assistant Business Office Manager, and Business Office Manager. The results of the audits conducted by Medical Records were reviewed during the QAPI meeting. The facility CPR Policy and No Code Policy were reviewed with no changes. The SA validated that the facility implemented the following systems, as discussed in Ad HOC QAPI, to ensure ongoing compliance on 06/03/19, by observation , interview and record review: a. Audit of all new admissions Advance Directive and code status system review to include code status order, Advance Directive, Care Plan and Kardex, MD Progress Note and color coded door tags, b. Colored door tags of red (DNR) and green (Full Code) are utilized to help identify code status for all residents, new residents door tag are applied upon admission or with an Advance Directive change, after verification to signed Advance Directive and Physician's order by Medical Records. 11. The SA validated by in-service and sign-in sheets, that on 06/03/19, the direct care staff was in-serviced by the Administrator, DON, ADON, Corporate Nurse Specialist, SDC, Medical Records, and RT on the color coded door tags, implemented on 06/03/19, to assist the direct care staff in identifying the resident code status, red (DNR) and green (Full Code). The SA validated that all corrective actions to remove the IJ were completed on 06/05/19, and the Immediate Jeopardy removed on 06/06/19.	M 500		