| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 255140 | A. BUILDING _____ B. WING _____ | C 06/21/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE BLUFFS REHABILITATION AND HEALTHCARE CENTER | 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) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS | F 000 | | |

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) performed, per the instructions in his Advance Directive, physician's order, and care plan. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited regulatory deficiencies at F578, F656, and F678.

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 Advance Directive, follow the care plan and perform CPR per orders, 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.

The IJ and SQC existed at:
CFR(s): 483.24 (a)(3); Cardio-pulmonary

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/12/2019 |

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| F 000 | Continued From page 1<br>Resuscitation (CPR)-F678; and,<br><br>IJ existed at:<br>CFR(s): 483.10 (c)(6)(8)(g)(12)(i)-(v); Formulate Advance Directive-F578; and,<br>CFR(s): 483.21 (b)(1); Develop/Implement Comprehensive Care Plan-F656.<br><br>The facility submitted a credible removal plan on 6/20/19, in which the facility alleged all corrective actions to remove the IJ was completed on 6/5/19, and the IJ removed on 6/6/19.<br><br>The SA validated the facility's removal plan prior to exit on 6/21/19, 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 CFR(s): 483.24 (a)(3); Cardio-pulmonary Resuscitation (CPR)-F678; CFR(s): 483.10 (c)(6)(8)(g)(12)(i)-(v); Formulate Advance Directive-F578; and CFR(s): 483.21 (b)(1); Develop/Implement Comprehensive Care Plan-F656, were lowered to a "D" 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.<br><br>The facility will remain out of compliance related to deficiencies on the annual recertification survey of 4/22/19, and complaint survey of 5/14/19.<br><br>The facility had a license for 120 beds, with a census of 98. | F 000 | | |
| F 578 SS=J | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir | F 578 | | 6/25/19 |

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| F 578 | Continued From page 2<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§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.<br><br>§483.10(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.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(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.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(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.<br>(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.<br>(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. | F 578 | | |

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| F 578 | Continued From page 3<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and policy review, the facility failed to honor an Advance Directive for a full code status, for one (1) of six (6) residents reviewed. Resident #1. Resident #1 had an Advance Directive for Cardio-pulmonary Resuscitation (CPR), and the facility failed to perform CPR, when Resident #1 was found without a pulse and without respirations, on 6/2/19. Resident #1 expired in the facility.<br><br>The facility's failure to honor the Advance Directive of a full code status and the failure to perform CPR, on 6/2/19, when Resident #1 was found unresponsive, without pulse or respirations, placed this resident and other resident's with the Advance Directive of full code status in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>The situation was determined to be an Immediate Jeopardy (IJ), which began on 6/2/19, when the facility failed to honor Resident #1's Advance Directive to perform CPR when the resident 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. The facility provided a removal plan, in which the facility alleged all corrective actions to remove the IJ were completed on 6/5/19, and the IJ removed as of 6/6/19.<br><br>The SA validated the facility's removal plan and determined the IJ was removed on 6/6/19, prior to | F 578 | Preparation and submission of this plan of correction by The Bluffs Rehabilitation and Healthcare, does not constitute an admission or agreement by the provider of truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws.<br><br>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).<br><br>2. Residents with the Advance Directive of | |

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| F 578 | Continued From page 4<br>exit on 6/21/19. Therefore the scope and severity of CFR(s): 483.10 (c)(6)(8)(g)(12)(i)-(v); Formulate Advance Directive-F578, 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.<br><br>Findings include:<br><br>Review of the facility's policy entitled, "Advance Directives", revised 04/13, revealed, "Policy Statement, Advance directives will be respected in accordance with state law and facility policy".<br><br>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 (BIMS), which indicated Resident #1 had moderately impaired cognitive abilities.<br><br>Review of the "Resident/Family Consent for Cardiopulmonary Resuscitation", dated 03/04/16, revealed the following: 1. "This facility requests that a written signature of the resident be obtained in advance regarding his/her wishes in regard to the desire for cardiopulmonary resuscitation (CPR) in the event of extreme emergency." 2."This statement will remain in effect as long as the resident remains a resident of this facility or until we receive a written and signed notice of revocation from you". 3. The form also included a check mark by the statement, "I understand that CPR constitutes an | F 578 | 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 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.<br><br>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 | |

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| F 578 | Continued From page 5<br>extraordinary measure and SHOULD be done on (Resident #1)".<br><br>Review of the "Order Summary Report", as of April 2019, confirmed Resident #1 had an order for a full code, for "CPR" to be performed.<br><br>Review of the "Progress Notes" for Resident #1 revealed the following:<br>1. A note for 06/02/19 at 10:25 PM for, "(Resident #1) is DNR (Do Not Resuscitate)". This entry was signed by Licensed Practical Nurse #2, and did not indicate any lifesaving efforts had been attempted.<br>2. A note, for 06/03/19 at 12:39 AM, by Respiratory Therapist (RT) #1 revealed "(LPN #1) stated that (Resident #1) had passed (was deceased) and she (LPN #1) was calling hospice. (LPN #1) confirmed DNR (Do Not Resuscitate)".<br><br>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 saw hospice staff. LPN #3 documented she was told by LPN #2 that Resident #1 was found deceased at 10:00 PM. LPN #3 documented that when she checked the resident's chart, she 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 he did not, because he thought Resident #1 was a DNR and did not check the chart.<br><br>Interview, on 06/18/19 at 12:25 PM, with LPN #2 revealed he had been assigned to Resident #1 on the night shift, which began on 06/02/19. He stated that he had been providing care to another resident when he was informed Resident #1 was deceased, and LPN #1 was notifying hospice of | F 578 | (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 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.<br><br>4. Beginning weekly on 6/5/2019, for four (4) weeks, then Monthly x 2 months, an | |

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| F 578 | Continued From page 6<br>the resident's death. LPN #2 stated he would have done CPR if he had known the Resident had an Advance Directive for a full code, but he thought the Resident must have a DNR order, since hospice was being notified.<br><br>Interview on 06/18/19 at 12:50 PM, with LPN #1, revealed she had looked in Resident #1's clinical record for the code status after she determined the resident did not have a pulse or respirations, but stated she had been unable to locate the code status. LPN #1 stated she thought the resident had a DNR status since he was on hospice. LPN #1 stated that she did find a notice in the chart to call hospice first, instead of 911. LPN #1 also stated she had informed LPN #2 she thought Resident #1 had a DNR status. LPN #1 confirmed she had not provided CPR to Resident #1.<br><br>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:<br><br>Brief Summary<br>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 | F 578 | 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 is 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 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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| F 578 | Continued From page 7 | F 578 | | |

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 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,

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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.

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

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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 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)

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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.

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

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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 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

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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 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.

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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 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

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| F 578 | Continued From page 14<br>include code status order, Advance Directive, Care Plan and Kardex, MD Progress Note and color coded door tags,<br>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.<br><br>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).<br><br>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. | F 578 | | |
| F 656 SS=J | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain | F 656 | | 6/25/19 |

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| F 656 | Continued From page 15<br>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and policy review, the facility failed to implement the care plan for the advanced directive for "Full Code" for one (1) of six (6) residents reviewed, Resident #1. The resident expired in the facility on 6/2/19. Resident #1 had a care plan for an Advance Directive for full code status, and the facility failed to follow the care plan to perform Cardio-pulmonary Resuscitation (CPR) when | F 656 | 1. Resident Identifier (RI)#1 care plan and orders reviewed on 6/3/2019, for verification of code status,following code status, and documentation of code status . RI#1 expired 6/2/2019.<br><br>2. All residents with a care plan for full code status have the potential to be affected by the deficient practice | |

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| F 656 | Continued From page 16<br>Resident #1 was found without a pulse and without respirations, on 6/2/19.<br><br>The facility's failure to follow the care plan for the Advance Directive of a full code, and failure to perform CPR on 6/2/19, when Resident #1 was found unresponsive, without pulse or respirations, placed this resident and other residents with a care plan for full code status in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>The situation was determined to be an Immediate Jeopardy (IJ), which began on 6/2/19, when the facility failed to follow the care plan for Resident #1's Advance Directive to perform CPR, when the resident 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.<br><br>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): 483.21 (b)(1); Develop/Implement Comprehensive Care Plan-F656, 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.<br><br>Findings include:<br><br>Review of the facility's "Using the Care Plan" policy, revised 08/06, revealed, "Policy | F 656 | On 6/3/2019, an audit was conducted by Medical Records on all current residents to ensure care plans is in place for Code Status/ Advance Directives for code status 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 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.<br><br>3. 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. On | |

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| F 656 | Continued From page 17<br>Statement, The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have the responsibility for providing care or services to the resident".<br><br>Review of the care plan for Resident #1, provided by the facility as the resident's current care plan, revealed, "My responsible party has been provided the information explaining the Advanced Directive process and following the education, my family has decided that I am a (FULL CODE)". The "Goal" was for "My (FULL CODE) status will be honored by my family and staff".<br><br>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.<br><br>Review of the "Resident/Family Consent for Cardiopulmonary Resuscitation", dated 03/04/16, revealed Resident #1 was a "Full Code", this was signed by the Responsible Party."<br><br>Review of a facility's investigation, dated 6/5/19, 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, per the care plan. 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 saw hospice staff. LPN #3 documented she was told by LPN | F 656 | 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 implementation and following care plans, how to identify code status and door tag system.<br><br>4. Beginning 6/5/2019, an audit will be conducted weekly for four (4) weeks, then monthly for two (2) months by the Director of Nursing/Assistant Director of Nursing to review three (3) residents care plan for implementation to ensure care plan is followed. On 6/5/2019, code drills willbe performed by Respiratory Therapy or Nurse Supervisor, unannounced on varying shift weekly x four (4) weeks then Monthly x three (3) months, to verify code status identification and implementation as per plan of care. Any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months by the Director of Nursing for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance. | |

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#2 that Resident #1 was found deceased at 10:00 PM. LPN #3 documented that when she checked the resident's chart, she 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 he did not, because he thought Resident #1 was a DNR and did not check the chart.

Interview, on 06/18/19 at 12:50 PM, with Licensed Practical Nurse (LPN) #1 confirmed she had not referred to the Care Plan for Resident #1's code status. LPN #1 was the first nurse in the room. LPN #1 stated the resident wasn't breathing and she called for the Respiratory Therapist, who confirmed the resident was pulseless and not breathing. LPN #1 stated she did not do CPR, because she thought the resident was not a full code, due to hospice status.

Interview, on 06/19/19 at 12:20 PM, with the Registered Nurse (RN) responsible for the MDS and Care Plans, confirmed the staff should have followed the instructions in the Care Plan for Advance Directives for Resident #1.

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

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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 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

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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.

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

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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 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

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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.

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

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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 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.

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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 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

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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 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

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| F 656 | Continued From page 26<br>implemented the following systems, as discussed in Ad HOC QAPI, to ensure ongoing compliance on 06/03/19, by observation , interview and record review:<br>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,<br>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.<br><br>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).<br><br>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. | F 656 | | |
| F 678 SS=J | Cardio-Pulmonary Resuscitation (CPR)<br>CFR(s): 483.24(a)(3)<br><br>§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. | F 678 | | 6/25/19 |

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| F 678 | Continued From page 27<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>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.<br><br>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.<br><br>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 | F 678 | 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).<br><br>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 was followed, advance directives matched the code status order, and the care plan | |

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| F 678 | Continued From page 28<br>of CFR(s): 483.24 (a)(3); Cardio-pulmonary Resuscitation (CPR)-F678, 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.<br><br>Findings Included:<br><br>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)".<br><br>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.<br><br>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.<br><br>Review of a facility investigation, dated 6/5/19, 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 | F 678 | matched the code status and advance directives with no negative findings. This was completed by Medical Records on 6/3/2019.<br><br>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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| F 678 | Continued From page 29<br>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.<br><br>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.<br><br>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.<br><br>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 noticed later, when LPN #3 was looking at Resident #1's chart after the staff from hospice | F 678 | 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.<br><br>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 | |

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| F 678 | Continued From page 30<br>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.<br><br>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.<br><br>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).<br><br>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 records. | F 678 | is followed, advance directives matched the code status order, and the care plan 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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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 actions:

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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| F 678 | Continued From page 32<br>approximately 12:00 AM, by LPN #3, that Resident #1 had expired and did not receive CPR.<br><br>Corrective Action<br>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.<br><br>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.<br><br>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.<br><br>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. | F 678 | | |

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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

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orders, and that the Care Plan matched the code status and Advanced Directive, with no negative 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

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Advance Directive and Physician's order by Medical Records.

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.

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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 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

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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 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

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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 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).

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| F 678 | Continued From page 39<br><br>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. | F 678 | | |