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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/06/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504		
(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
F 279	<p>Continued From page 59</p> <p>Interviews on 03/04/15: at 3:20 PM with LPN #8; at 3:49 PM with SRNA #13; at 4:15 PM with LPN #2/MDS Nurse; at 4:30 PM with SRNA #6; at 4:50 PM with RN #4/MDS Coordinator and SRNA #2; at 4:58 PM with SRNA #12; at 5:15 PM with LPN #1/Supervisor; at 5:20 PM with LPN #4; and at 5:50 PM with SRNA #8/KMA and RN #5; and interviews on 03/06/15: at 12:36 PM with LPN #10/Weekend Supervisor; at 1:00 PM with SRNA #19 and SRNA #14; at 2:00 PM with SRNA #15; at 2:30 PM with SRNA #16/KMA; at 3:35 PM with SRNA #1; at 3:50 PM with SRNA #11; at 4:00 PM with SRNA #10; at 4:05 PM with LPN #9; at 4:25 PM with LPN #3; at 4:40 PM with SRNA #9; and at 4:50 PM with RN #5 revealed they had all received in-service education regarding differentiation of DNR and Full Code status, how to identify a resident's code status, how to call for and initiate a Code Blue, who should respond to a Code Blue immediately, where to locate the crash carts, contacting the Physician and calling 911, continuation of a code until EMS arrived, notification of the DON and Administrator, and documentation of all details of the code in the medical record. Additionally, the staff interviewed revealed they had also been educated on how to manage a resident who had a DNR status, and had to take a post-test and score 100%.</p> <p>Interview on 03/06/15: at 4:00 PM with SS #2; at 4:30 PM with SS #13; and at 5:30 PM with the SDC, revealed they had all participated in the training of all facility nursing staff on the facility's Code Blue policy and procedure, protocol and process to manage a resident with a DNR status, verify no vital signs at five minute intervals, pronouncement of death and notification of Physician, family/POA, DON, and Administrator and documentation in the medical record, which</p>		<p>continue to conduct this audit daily Monday thru Friday by the QA nurse and the Medical Records Coordinator and is being conducted on the weekends by the weekend house supervisor. If any discrepancies are found, corrections will be made immediately. The audits is being submitted to the DON daily for review. In addition, the results of these audits are being submitted by the DON to the QAA monthly meetings for review and recommendations. The daily auditing will continue until substantial compliance is determined by the Office of the Inspector General (OIG). Once substantial compliance is achieved, these audits will continue on a monthly basis for the following six (6) months. These results will continue to be presented to the QAA committee by the DON. After six (6) months, the QAA committee will determine frequency of continual auditing to maintain future compliance.</p> <p>On 2-19-15, the DON developed a Code Blue reference book for each crash cart for the licensed nurses. In-services were initiated on 2-19-15 and completed on 3-1-15 for all nursing staff, including, RNs, LPNs, and SRNAs.</p> <p>On 2-19-15, the Central Supply Coordinator audited each of the six (6) code crash carts to validate that items were present and within expiration.</p>	

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F 279	<p>Continued From page 60</p> <p>required a post-test with 100% accuracy, with immediate re-education provided for any incorrect answers.</p> <p>Interview, on 03/05/15 at 5:55 PM, with the DON revealed she had participated in the training of all nursing staff on the facility's Code Blue policy and procedure, protocol, and process to manage a resident with a DNR status, verify no vital signs at five minute intervals, pronouncement of death and notification Physician, family/POA, DON, and Administrator and documentation in the medical record. Per interview, each area required a post-test with 100% accuracy, with immediate re-education provided for any incorrect answers. The DON further stated two (2) staff members were out on leave and did not receive the training; however, would not be added to the schedule until they were in-serviced and completed the post-test with 100 % accuracy.</p> <p>20. Review of the facility's in-service sign in sheets and post test on 03/06/15, for 02/27/15 through 03/02/15, revealed nursing staff (Nurses, KMAs and SRNA's) had received education on the facility's requirement for inclusion of the resident's Advanced Directives and code status on the Comprehensive Care Plan.</p> <p>Interviews on 03/04/15: at 3:20 PM with LPN #8; at 3:49 PM with SRNA #13; at 4:15 PM with LPN #2/MDS Nurse; at 4:30 PM with SRNA #8; at 4:50 PM with RN #4/MDS Coordinator and SRNA #2; at 4:58 PM with SRNA #12; at 5:15 PM with LPN #1/Supervisor; at 5:20 PM with LPN #4; and at 5:50 PM with SRNA #8/KMA and RN #5; and interviews on 03/06/15: at 12:35 PM with LPN #10/Weekend Supervisor; at 1:00 PM with SRNA #19 and SRNA #14; at 2:00 PM with SRNA #15;</p>		<p>The audit showed 6/6 crash carts were properly stocked with no expired equipment.</p> <p>These carts are being checked Monday-Friday by the Central Supply Coordinator, and checked Saturday-Sunday by the House Supervisor. The items in the carts will be accounted for on the facility Crash Cart Check List Form indicated by the Central Supply Coordinator/Nursing Supervisor's signature, date, and comment as to whether all items are present and within expiration. The results of these audits are being delivered by the Central Supply Coordinator/House Supervisor to the Administrator and DON for review to ensure immediate compliance.</p> <p>In the event an error is found, it will be immediately corrected. These audits are being presented by the Administrator or DON to the monthly QAA Committee for interdisciplinary review. The QA Committee will authorize any change to the plan of correction for frequency of audits or further needed interventions; however, these audits are scheduled to continue Monday-Friday indefinitely.</p> <p>The following has been added to the facility's orientation program on 2-28-15 by the DON for newly hired licensed staff and when agency staff is utilized which includes in-services and post tests for Professional Nursing</p>	
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F 279	<p>Continued From page 61</p> <p>at 2:30 PM with SRNA #16/KMA; at 3:35 PM with SRNA #1; at 3:50 PM with SRNA #11; at 4:00 PM with SRNA #10; at 4:05 PM with LPN #9; at 4:25 PM with LPN #3; at 4:40 PM with SRNA #9; and at 4:50 PM with RN #6 revealed they had all received in-service education regarding the requirement for inclusion of a resident's Advance Directives and code status on the Comprehensive Care Plan. Additionally, the staff interviewed revealed they all had taken a post-test and had to score 100%.</p> <p>Interview with the SDC on 03/06/15 at 5:30 PM, revealed she had participated in the training of all nursing staff on the facility's requirement for inclusion of the resident's Advance Directives and code status on the Comprehensive Care Plan. Per interview, a post-test was required with 100% accuracy, with immediate re-education provided for any incorrect answers.</p> <p>Interview, on 03/06/15 at 5:55 PM and 6:30 PM, with the DON revealed she had participated in the training of all staff on the facility's requirement for inclusion of the resident's Advance Directives and code status on the Comprehensive Care Plan. Per interview, a post-test was required with 100% accuracy, with immediate re-education provided for any incorrect answers. Further interview revealed two (2) staff members were out on leave and did not receive the training; however, would receive the training prior to being added to the schedule, and would have to complete the post-test as required, but will not be added to the schedule until they are in-serviced and complete the post-test accurately.</p> <p>21. Review on 03/06/15, of the 02/27/15 code status audits revealed fifty-six (56) of one</p>		<p>Standards; Identifying Code Status and post test; Policy and procedure of comprehensive care plans and post test; Advance directives and post test; Resident rights and post test; Code Blue information sheet to be completed at the time of a code blue; Code Blue Nurse's note guide and post test; Code Blue Protocol and post test and each licensed nurse must have a current CPR certification.</p> <p><i>Monitoring</i> Initiation of investigating all code blue events: On 2-19-15, the DON developed a Code Blue information form to be attached to the incident report for all Code Blue events and turned into the Director of Nursing for investigation. In-servicing regarding the facility's new Code Blue information form was initiated on 2-19-15 and completed on 3-1-15 for all nursing staff; including, RNs, LPNs, and SRNAs.</p> <p>Results of the investigation will be submitted to the QAA monthly meeting by the DON. There has not been a code blue event other than mock drills since Resident #1.</p> <p>The Staff Development Coordinator will conduct monthly in-services for the next 6 months and then quarterly with all nursing staff on facility policy and procedure related to advance directives and Code Blue policy and</p>	

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F 279 Continued From page 62
hundred and twenty-eight (128) residents had a Full Code status as per their Advance Directives.

Interview with MR on 03/06/15 at 3:50 PM, revealed she and the QA Nurse had audited all residents' records on 02/27/15, and fifty-six (56) of those residents' records had an Advance Directive for Full Code status.

22. Interview, on 03/06/15 at 5:30 PM, with the SDC revealed the new hire orientation packet did include the new training and post-test related to professional nursing standards, Comprehensive Care Plans, Advance Directives, identifying code status, facility's Code Blue protocol and new Code Blue forms. Per interview, the post-test would be required with a 100% accuracy, and immediate re-education provided for any incorrect answers.

Interview, on 03/06/15 at 6:30 PM, with the DON revealed all agency staff received orientation packets to educate them on the same topics as facility staff. Per interview, all agency staff would complete the post-test with 100% accuracy prior to providing direct care.

Interview, on 03/06/15 at 1:00 PM, with RN #7, an agency nurse, revealed she did receive the facility's in-service training and had completed a post-test for each topic regarding the facility's protocol for Advance Directives, code status, Comprehensive Care Plan, Resident Rights, and Code Blue documentation forms.

23. On 03/06/15, review of the facility's in-service sign in sheets and post test for 02/28/15 through 03/02/15, revealed nursing staff (Nurses, KMAs and SRNA's) did received education related to

procedure and policy and procedure on comprehensive care plans will be covered in these in-services. These in-services are scheduled for 4/6/15, 5/4/15, 6/1/15, 7/6/15, 8/3/15, and 9/7/15.

A mock Code Blue drill was conducted on 3-3-15, 3/16/15, and on 3/20/15, and will be conducted quarterly by the Staff Development Coordinator, QA nurse or DON on all three (3) shifts both weekends and weekdays. Results of these drills are being documented by the Staff Development Coordinator, QA nurse or DON and submitted to the DON and Administrator for review. Additionally, the results of these drills are being submitted by the Administrator or DON to the facility QAA meeting for interdisciplinary review.

An audit was initiated on 2-19-15 for the QA Nurse and the Medical Records Coordinator comparing each residents advance directive decisions, physician's orders including code status, comprehensive care plan, code status identification on the spine of the chart which is white for full code and red for DNR, and identification on the residents door of a red dot if a DNR status, and making sure that they match and that there were no discrepancies in the policy. This audit consisted of 100% of the facility's residents (128/128 residents).

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F 279	<p>Continued From page 63</p> <p>professional nursing standards, pertaining to provision of CPR, documentation, ensuring a Physician's order for DNR status and honoring each resident's Advance Directives.</p> <p>Interviews on 03/04/15: at 3:20 PM with LPN #8; at 3:49 PM with SRNA #13; at 4:15 PM with LPN #2/MDS Nurse; at 4:30 PM with SRNA #6; at 4:50 PM with RN #4/MDS Coordinator and SRNA #2; at 4:58 PM with SRNA #12; at 5:15 PM with LPN #1/Supervisor; at 5:20 PM with LPN #4; and at 5:50 PM with SRNA #8/KMA and RN #5; and Interviews on 03/06/15: at 12:35 PM with LPN #10/Weekend Supervisor; at 1:00 PM with SRNA #19 and SRNA #14; at 2:00 PM with SRNA #15; at 2:30 PM with SRNA #16/KMA; at 3:35 PM with SRNA #1; at 3:50 PM with SRNA #11; at 4:00 PM with SRNA #10; at 4:05 PM with LPN #9; at 4:25 PM with LPN #3; at 4:40 PM with SRNA #9; and at 4:50 PM with RN #8 revealed they had all received in-service education regarding professional nursing standards which pertained to provision of CPR, documentation, ensuring a Physician's Order for a DNR status and honoring a resident's Advance Directives. Additionally, the staff interviewed revealed they all had taken a post-test and had to score 100%.</p> <p>24. Review of the 03/03/15 Mock Code Blue sign-in sheet revealed seven (7) LPN's, one (1) RN, five (5) SRNA's and MR responded to the Mock Code Blue drill. Review of the Incident/Accident form, Nurse's Note, Code Blue Information form, and Code Blue Nurse's Notes Guide revealed the staff responded timely, and followed the facility's protocol for a Code Blue.</p> <p>Interviews, on 03/06/15 at 1:30 PM, with SRNA #2, at 2:10 PM, with SRNA #18, revealed they</p>		<p>There were no corrections needed from these audits but the facility will continue to conduct this audit daily Monday thru Friday by the QA nurse and the Medical Records Coordinator and is being conducted on the weekends by the weekend house supervisor. If any discrepancies are found, corrections will be made immediately. The audits is being submitted to the DON daily for review. In addition, the results of these audits are being submitted by the DON to the QAA monthly meetings for review and recommendations. The daily auditing will continue until substantial compliance is determined by the Office of the Inspector General (OIG). Once substantial compliance is achieved, these audits will continue on a monthly basis for the following six (6) months. These results will continue to be presented to the QAA committee by the DON. After six (6) months, the QAA committee will determine frequency of continual auditing to maintain future compliance.</p> <p>On 2-19-15, the Central Supply Coordinator audited each of the six (6) code crash carts to validate that items were present and within expiration. The audit showed 6/6 crash carts were properly stocked with no expired equipment.</p>		

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F 279	Continued From page 64 had participated in the mock Code Blue on 03/03/15. SRNA #2 and SRNA #18 stated the drill went very well, and everyone seemed to be more comfortable with their role in a Code Blue event. Interview, on 03/06/15 at 1:45 PM, with LPN #1/Supervisor revealed she had taken the lead in the mock Code Blue, and after assessing the mock resident for vital signs had given the order to page a Code Blue. Per interview, she informed those present to get the crash cart, and CPR was initiated timely and documentation was completed. She further stated she felt good about the mock Code Blue. Interview, on 03/06/15 at 5:30 PM, with the SDC revealed a mock Code Blue drill would be completed quarterly on all shifts and on weekends.		These carts are being checked Monday-Friday by the Central Supply Coordinator, and checked Saturday-Sunday by the House Supervisor. The items in the carts will be accounted for on the facility Crash Cart Check List Form indicated by the Central Supply Coordinator/Nursing Supervisor's signature, date, and comment as to whether all items are present and within expiration. The results of these audits are being delivered by the Central Supply Coordinator/House Supervisor to the Administrator and DON for review to ensure immediate compliance. In the event an error is found, it will be immediately corrected. These audits are being presented by the Administrator or DON to the monthly QAA Committee for interdisciplinary review. The QA Committee will authorize any change to the plan of correction for frequency of audits or further needed interventions; however, these audits are scheduled to continue Monday-Friday indefinitely.		
F 281 SS=J	483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and procedures, and review of the Kentucky Board of Nursing's (KBN's), "Accountability & Responsibility of Nurses" document and Advisory Opinions (AOS), it was determined the facility failed to have an effective system to ensure services provided met professional standards of quality for one (1) of eight (8) sampled residents (Resident #1)		The following has been added to the facility's orientation program on 2-28-15 by the DON for newly hired licensed staff and when agency staff is utilized which includes in-services and post tests for Professional Nursing Standards; Identifying Code Status and post test; Policy and procedure of comprehensive care plans and post		

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F 281	Continued From page 85 regarding ensuring nursing staff honored the resident's Advance Directives. On 09/11/12, Resident #1 signed a document stating he/she requested to be a Full Code (Full Code indicates life-saving measures would be instituted in the event of cardiac or respiratory failure) to include Cardiopulmonary Resuscitation (CPR). However, on 02/18/15, Registered Nurse (RN) #1 and RN #2 failed to ensure Resident #1's Advance Directives were honored regarding the Full Code. On 02/18/15 at approximately 8:30 AM, State Registered Nursing Assistant (SRNA) #1 found Resident #1 unresponsive and immediately notified RN #1 who assessed the resident; however, did not immediately initiate the facility's Code Blue process or CPR for Resident #1. SRNA #1 also notified RN #2 of the resident being unresponsive, and RN #2 also failed to initiate the facility's Code Blue process and CPR. Instead RN #2 overhead paged Licensed Practical Nurse (LPN) #1/Supervisor who responded and came to Resident #1's room where she told RN #1 and RN #2 to initiate CPR. However, LPN #1/Supervisor failed to ensure CPR was initiated and called the Minimum Data Set (MDS) office to verify if a Full Code resident was found unresponsive should CPR still be initiated. At approximately 9:05 AM, LPN #2/MDS Nurse and RN #4/MDS Coordinator went to Resident #1's room where CPR had still not been initiated. CPR was initiated per interview at approximately 9:05 AM to 9:10 AM, thirty-five (35) to forty (40) minutes, after the resident was found unresponsive, 911 was called, and Resident #1 was transported to the hospital Emergency Room (ER) where the resident was pronounced deceased at 9:38 AM.		test; Advance directives and post test; Resident rights and post test; Code Blue information sheet to be completed at the time of a code blue; Code Blue Nurse's note guide and post test; Code Blue Protocol and post test and each licensed nurse must have a current CPR certification. An Ad Hoc QA meeting was held 3/12/15; including the following members of the interdisciplinary team: Administrator, Director of Nursing, Medical Director, Regional Director of Clinical Services, Quality Assurance Nurse, and Nursing Supervisor. The Medical Director was informed of and approved all steps taken to ensure both immediate and ongoing compliance. Date of Correction: March 24, 2015	3-24-15

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F 281	<p>Continued From page 66</p> <p>The facility's failure to ensure nursing staff implemented its Code Blue process and honored residents' Advance Directives regarding their requested code status has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/26/15, and was determined to exist on 02/18/15. The facility was notified of the Immediate Jeopardy on 02/26/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/04/15 with the facility alleging removal of the Immediate Jeopardy on 03/04/15. Immediate Jeopardy was verified to be removed on 03/04/15 as alleged by the State Survey Agency prior to exit on 03/05/15, with remaining non-compliance at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the KBN's, "Accountability & Responsibility of Nurses" document revealed KRS 314.021 (2) held nurses individually responsible and accountable for rendering safe, effective nursing care to clients and for judgements exercised and actions taken in the course of providing care.</p> <p>Review of the KBN's Advisory Opinion Statement (AOS) #36 "Resuscitation", approved February 2008, revealed nurses were "required" to honor the Advance Directives of "patients" who had the Advance Directives documented in their medical record, unless a Physician or healthcare facility refused to comply, and the "patient" and</p>	F 281		
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F 281	<p>Continued From page 57 surrogate were informed of the refusal.</p> <p>Review of the facility's policy titled, "Cardiopulmonary Resuscitation (CPR)", undated, revealed if staff found a resident unresponsive they should call for help, assess the resident, check the resident's code status. If the resident was a Full Code call "paramedics" (911), initiate CPR and continue it until the "paramedics" arrived.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 06/22/12, and re-admitted him/her on 09/05/14. Continued record review revealed on 09/11/12, Resident #1 had signed a document requesting to have CPR provided in the event he/she was non-responsive. Review of the February 2015 Physician's Orders revealed an order for Resident #1 to have a Full Code status.</p> <p>Review of the Nurse's Notes revealed a Note dated 02/18/15 timed 8:40 AM documented by RN #1. Review of the Note revealed SRNA #1 had called RN #1 to Resident #1's room because the resident didn't "look too good". Per the Note, RN #1 found Resident #1 unresponsive after shaking the resident and checking for pulses and respirations. However, continued review of the Note revealed no documented evidence she immediately called a "Code Blue" or immediately initiated CPR for Resident #1 who had a Full Code status. The Note revealed RN #1 documented she called for "assist" from a nurse on another unit, and when the other nurse arrived 911 was called and CPR was then initiated. Further review of the Note revealed RN #1 documented 911 was there at 9:10 AM.</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1508 VERSAILLES ROAD LEXINGTON, KY 40504		
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F 281	<p>Continued From page 68</p> <p>Review of the EMS Run Sheet dated 02/18/15, revealed EMS was notified by the facility at 9:08:54 AM, were enroute at 9:08:03 AM, at 9:13:14 were with the "patient" (Resident #1). Continued review of the Run Sheet revealed EMS departed the facility with Resident #1 at 9:22:16 AM and arrived at the hospital ER at 9:29:37 AM. Further review revealed EMS assessed no vital signs for Resident #1 and noted his/her skin color was pale, skin temperature was cool and the resident's pupils were fixed.</p> <p>Review of the hospital ER record dated 02/18/15 revealed EMS arrived with Resident #1 and the resident was triaged at 9:33 AM. Per the ER record, Resident #1 presented to the ER in "cardio-pulmonary arrest", was treated for the condition, but remained in asystole (no heart rate). The ER record noted Resident #1 was pronounced as deceased at 9:38 AM.</p> <p>Review of the facility's investigation documentation dated 02/18/15, revealed an investigation had been conducted regarding an allegation of neglect involving Resident #1. Per the documentation, SRNA #1 found Resident #1 non-responsive at approximately 8:45 AM that morning and notified RN #1, who "due to her emotional state over" Resident #1 expiring had not honored the resident's Advance Directives "by initiating a Full Code". Continued review revealed other nurses had to initiate CPR for Resident #1 until EMS arrived. The investigation documentation revealed Resident #1 had "selected" to be a Full Code which was "indicated by" the resident's signature and was in the medical record. Review of the Form revealed RN #1 and RN #2 had been suspended pending the</p>	F 281		

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F 281	<p>Continued From page 69 investigation outcome.</p> <p>Review of RN #1's written statement dated 02/18/15 at 3:25 PM, documented by the Director of Nursing (DON), revealed RN #1 reported SRNA #1 came to her at "about 8:45 AM", and said she needed to come and see Resident #1. Per the written statement, RN #1 went to Resident #1's room, shook him/her and checked for a pulse, but the resident had none. According to the statement, she also assessed Resident #1's vital signs and "there were none". The written statement noted RN #1 sent SRNA #1 to get a nurse on another unit, RN #2, who arrived in approximately one (1) minute. However, review of the written statement revealed no documented evidence RN #1 called a "Code Blue" or initiated CPR for Resident #1. Continued review of the written statement revealed RN #1 knew the white label on the spine of a resident's medical record indicated the resident was a Full Code, but she didn't know "why she did not call the code". RN #1's written statement noted CPR was not initiated until after another nurse, LPN #1/Supervisor came to Resident #1's room and told her and RN #2 to "code" the resident. Further review of RN #1's written statement revealed she initially "could not do this to" Resident #1 (provide CPR); however, after being told to she did "code" the resident. In addition, it was noted RN #1 thought CPR "started within five (5) minutes".</p> <p>Interview with RN #1 was attempted on 02/24/15 at 1:05 PM, 2:00 PM, 4:30 PM and 5:15 PM, and on 02/25/15 at 10:10 AM; however was unsuccessful each time.</p> <p>Continued review of the facility's investigation</p>	F 281		

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F 281	<p>Continued From page 70</p> <p>documentation revealed RN #2's written statement dated 02/18/15 (timed 3:20 PM, which was documented by the DON. Per RN #2's written statement, SRNA #1 came and got her on 02/18/15 and told her RN #1 needed her. Review revealed when RN #2 arrived in Resident #1's room, she found RN #1 sitting on the resident's bed crying. According to RN#2's written statement, she checked Resident #1 for a pulse and did not find a pulse, and checked the resident's pupils. RN #2's written statement revealed she asked RN #1 the Resident #1's code status, a Do Not Resuscitate (DNR) or a Full Code, and RN #1 told her he/she was a Full Code. Further review of RN #2's written statement revealed she was told by RN #1 she (RN #1) was not going to put Resident #1 "through it" (CPR). In addition, the written statement revealed no documented evidence RN #2 initiated the facility's "Code Blue" process or CPR for Resident #1. Review revealed RN #2 left Resident #1 room to get LPN #1/Supervisor's opinion, then CPR was initiated which was performed for "a good while".</p> <p>Interview, on 02/24/15 at 12:25 AM and 02/25/15 at 11:30 AM, with RN #2 revealed she should have started CPR when she first entered Resident #1's room the morning of 02/18/15. However, after RN #1 refused to do CPR for Resident #1 because she was not going to put the resident "through that", she felt she did not have any help (to perform CPR). Per interview, when she first entered Resident #1's room she did not know the resident's code status, but was told by RN #1 the resident was a Full Code. Further interview revealed she did not know how long it took to start "the code" (CPR), as she did not have her watch and hadn't looked at the</p>	F 281			

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F 281	<p>Continued From page 71</p> <p>clock. Per interview, CPR was not initiated until after LPN #1/Supervisor entered Resident #1's room and told her and RN #1 to initiate CPR.</p> <p>Further review of the facility's investigation documentation revealed LPN #1/Supervisor's written statement dated 02/18/15, unlimed. Per the written statement on 02/18/15 at approximately 9:00 AM, she was paged overhead to call RN #2. The written statement revealed when she called RN #2, she was told Resident #1 "was dead" and she needed to "get up" there. LPN #1/Supervisor went to Resident #1's room, as she went she saw the resident's chart which had a white label on it indicating he/she was a Full Code. The documentation revealed upon arrival to Resident #1's room she saw RN #1 sitting on the resident's bed patting his/her shoulder. According to the written statement, she asked why CPR was not initiated, and RN #1 told her she couldn't do that to Resident #1 as the resident would not want it. Per the written statement, LPN #1/Supervisor informed RN #1 that Resident #1 was a Full Code and she had to initiate CPR. LPN #1/Supervisor's written statement revealed she left Resident #1's room to call LPN #2/MDS Nurse to clarify if a resident was a Full Code and found non-responsive should CPR still be performed.</p> <p>Interview, on 02/24/15 at 12:05 PM, with LPN #1/Supervisor revealed on 02/18/15 at approximately 9:00 AM, she got to Resident #1's room after she had been paged overhead by RN #2. Continued interview revealed after arriving to Resident #1's room, she informed RN #1 and RN #2 CPR had to be started and 911 called. Per interview, RN #2 went to get the crash cart and LPN #1 went to call 911. Per interview, the "code"</p>	F 281		

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for Resident #1 was not performed timely, and CPR should have been initiated immediately after RN #1 assessed Resident #1, and observed the resident had no pulse and was not breathing.

Review of the facility's investigation documentation revealed LPN #2/MDS Nuras's written statement dated 02/19/15 timed 1:45 PM, which was documented by the DON. Per the written statement, she had received a call from LPN #1/Supervisor on 02/18/15, to "double check code policy". The statement revealed after the call she went to Resident #1's room and observed RN #1 and RN #2 standing by the resident's bed, and she had to tell the nurses to start CPR. LPN #2/MDS Nurse's statement noted she was told by the nurse's Resident #1 had been found unresponsive at approximately 8:45 AM. The documentation revealed RN #1 had tears in her eyes and told her she "didn't want to have to do CPR on" Resident #1, and she told RN #1 CPR had to be done as the resident was a Full Code.

Interview, on 02/24/15 at 2:40 PM, with LPN #2/MDS Nurse at approximately 9:00 AM to 9:05 AM on 02/18/15, LPN #1/Supervisor had called her to verify if a Full Code resident was found non-responsive whether CPR was still to be initiated. LPN #2/MDS Nurse stated she told LPN #1/Supervisor, "yes, CPR had to be initiated". Per interview, she left the MDS office and went immediately to Resident #1's room after the phone call. She stated after entering the resident's room she saw RN #1 holding an Ambu Bag (a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately) on one side of the bed, and RN #2

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F 281	<p>Continued From page 73</p> <p>standing on the opposite side of the bed with the crash cart. According to LPN #2/MDS Nurse, she had to tell RN #1 and RN #2 to hook oxygen up to the Ambu Bag and start CPR. Continued interview revealed however, RN #1 was "emotional" and told her she didn't want to do that (start CPR) to Resident #1, LPN #2/MDS Nurse revealed she explained to RN #1 they had to start CPR because Resident #1 was a Full Code. She stated RN #1 and RN #2 told her Resident #1 had been found non-responsive at approximately 8:45 AM.</p> <p>Review of the facility's investigation documentation revealed RN #4/MDS Coordinator's written statement dated 02/19/15 at 1:30 PM documented by the DON. Per the written statement on 02/18/15, LPN #1/Supervisor called the MDS office to "say that nurse was not coding" Resident #1, and she thought they should be coding the resident. Review revealed she and LPN #2/MDS Nurse went to Resident #1's room and saw RN #1 holding the Ambu Bag by the resident's bed, and RN #2 was standing on the other side of the bed. The statement revealed RN #4/MDS Coordinator told RN #1 and RN #2 they had to lay the head of Resident #1's bed flat, and start CPR, which was done.</p> <p>Interview, on 02/24/15 at 3:00 PM, with RN #4/MDS Coordinator revealed on 02/18/15 at about 9:00 AM, LPN #2/MDS Nurse received a call from LPN #1/Supervisor requesting verification if a resident was found "lifeless" and was a Full Code whether CPR should be initiated. RN #4/MDS Coordinator revealed she and LPN #2/MDS Nurse went to Resident #1's room after the call, and observed RN #1 holding the Ambu</p>	F 281		
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F 281	<p>Continued From page 74</p> <p>Bag by the resident's bed, and RN #2 on the other side of the bed. RN #4/MDS Coordinator stated however, they did not observe chest compressions being done. She stated she could not recall for sure if the RN's were using the Ambu Bag.</p> <p>Interview, on 2/24/15 at approximately 2:00 PM and on 02/26/15 at 6:05 PM, with the Director of Nursing (DON) revealed for a resident found not breathing, a nurse was to assess the resident and if no pulse or breathing was found, the nurse should check the resident's code status. Per interview, for residents who were a Full Code CPR should be started immediately. Per the DON, Resident #1's CPR was not immediately initiated, but should have been. She stated RN #1 showed "no remorse" when she talked to her during the investigation, and told her (DON) she "just didn't want to do that to" the resident. The DON stated the facility suspended RN #1 and RN #2 pending the results of the investigation, and RN #1 terminated her employment with the facility on 02/21/15. She stated RN #1 would be reported to the KBN by the facility.</p> <p>Interview, on 2/26/15 at 3:45 PM, with the Administrator revealed the nurse should be notified immediately if a resident was found non-responsive by a SRNA. The Administrator revealed, for a resident who was a Full Code, CPR should be immediately initiated and continued until EMS arrived and took over. Per interview, RN #1 did not act appropriately on 02/18/15. Further interview revealed RN #2 should have initiated the code but he felt RN #1 stood in RN #2's way. He stated RN #2 did notify the supervisor who informed RN #1 to start CPR.</p>	F 281			

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F 281	<p>Continued From page 75</p> <p>However, interview statements on 02/18/15 at 3:20 PM, with RN #2 and 02/24/15 at 12:05 PM, with LPN #1/Supervisor, revealed they had not initiated CPR for Resident #1 timely per the facility's policy which stated "if staff found a resident unresponsive they should call for help, assess the resident, check the resident's code status, if the resident was a Full Code call "paramedics" (011), initiate CPR, and continue it until the "paramedics" arrived".</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/03/15, that alleged removal of the IJ effective 03/04/15. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1. On 02/18/15, the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) interviewed State Registered Nursing Assistant (SRNA) #1, Nursing Supervisor (NS) #1 (LPN #1/Supervisor), RN #1 and RN #2 regarding delay of the Code Blue event involving Resident #1. RN #1 and RN #2 were suspended on 02/18/15 pending the facility's investigation. 2. On 02/18/15, an initial report of the delayed Code Blue event was sent to the State Agency by the Administrator and the DON. 3. On 02/18/15, the DON notified Resident #1's family of the delay in initiating a Code Blue by RN #1. 4. On 02/18/15, the Staff Development Coordinator (SDC) initiated in-services with licensed nurses regarding immediate implementation of the facility's Code Blue Protocol for residents who had Advance 	F 281			

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F 281	<p>Continued From page 76</p> <p>Directives which indicated a Full Code status. Immediate training included face-to-face in-services with licensed staff on duty, and instruction by telephone for other licensed staff. On 02/19/15, the training was extended to include SRNA's and Kentucky Medication Aides (KMAs), and 100% of the nursing staff received the education. Training points included the immediate initiation of CPR, based on the Physician's Orders and the individual's Advance Directives and stated wishes regarding their code status, when a resident was discovered to be without vital signs. Utilized for the training was the facility's Code Blue Protocol.</p> <p>5. On 02/19/15, the DON revised the facility's policy and procedure related to code status to include a requirement for adding each resident's code status to the care plan.</p> <p>6. On 02/19/15, the DON developed a new system of quarterly care plan meetings with the resident and/or their Responsible Party (RP), the Social Worker, the unit nurse and the MDS nurse, to determine if any change in code status is desired by the resident.</p> <p>7. On 02/19/15, the DON developed a Code Blue information form to be attached to the incident report for all Code Blue events. Both forms are turned in to the DON for further investigation. The DON will submit results of all investigations to the monthly QA meetings. In addition, the DON developed a reference book for Code Blue events, and placed a book on each crash cart.</p> <p>8. On 02/19/15, the Administrator notified the Ombudsman of the delay in inflating a Code Blue for Resident #1. The Administrator explained the</p>	F 281		
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F 281	<p>Continued From page 77</p> <p>corrective actions taken by the facility, and invited the Ombudsman to participate in the investigation process.</p> <p>9. On 02/19/15, a Quality Assurance (QA) meeting was held by telephone conference. Participants included the Administrator, the DON, and the Medical Director, who was also the Attending Physician for Resident #1. The purpose of the meeting was to notify the Medical Director of the delay in providing CPR for Resident #1, and to discuss corrective actions.</p> <p>10. On 02/19/15, an Ad Hoc QA meeting was held to establish corrective actions and monitoring to ensure future compliance related to the following: Code Blue response, residents' rights, and the facility's Abuse Policy. Attendees included the Administrator, DON, Medical Director, QA Nurse, RDCS, Regional Director of Operations (RDO), Unit Managers (UMs), and the SDC. The committee reviewed and authorized revision of the facility's current policy related to code status to include code status in each resident's Comprehensive Care Plan. In addition, the committee developed a checklist of items to be completed to ensure no other resident had the possibility of being affected by the deficient practice. Furthermore, the committee assigned individual members of the interdisciplinary team to carry out specific tasks stated on the check list, as well as, actions to ensure ongoing compliance. The committee determined the root cause of the delay in provision of CPR for Resident #1 was due to RN #1's failure to follow the facility's policy and procedure related to code status.</p> <p>Also, on 02/19/15, the regular monthly QA meeting was held and attended by the</p>	F 281			

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F 281	<p>Continued From page 78</p> <p>Adminlstrator, DON, Medical Director, Social Services Director (SSD), QA Officer, Nursing Supervisor, Activities Director (AD), Director of Rehabilitation, Consultant Dietician, and the Dietary Manager Assistant. Participants confirmed the Ad Hoc meeting determination of the root cause and further discussed the facility's plan of action going forward.</p> <p>11. On 02/19/15, the Medical Records Coordinator and the QA Nurse audited 100% of the 128 residents' charts to verify each resident's code status was correctly identified, and to ensure Physician Orders, Comprehensive Care Plans, and SRNA Care Plans were consistent for either Full Code or DNR status. Each resident's chart holds an identifying sticker on the outside spine to communicate the code status: a white sticker indicates a Full Code status, and a red sticker indicates DNR status. The Medical Records Coordinator updated each resident's Care Plan to reflect individual code status to be either Full Code or DNR. The QA Nurse and the Medical Records Coordinator will continue the audits daily Monday through Friday, and the House Supervisor will perform the audits on the weekends, until the IJ is removed. Audit results will be submitted daily for review by the DON, who will forward the data to the monthly QA meetings for interdisciplinary review.</p> <p>12. On 02/19/15, the Central Supply clerk audited the facility's six (6) crash carts, utilized for managing a Code Blue event, for the presence of adequate supplies, and to ensure no expired items were located on the carts. The crash carts will be checked daily, Monday through Friday by the Central Supply Clerk, and by the House Supervisor on weekends, until the IJ is removed.</p>	F 281			

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F 281	<p>Continued From page 79</p> <p>The audits will utilize the Crash Cart check List Form, and all results will be submitted to the Administrator and the DON for their review. Subsequently, audit results will be presented at the monthly QA meeting, where any changes to the frequency of audits, or recommendations for further interventions, will be made.</p> <p>13. Beginning 02/19/15, the Payroll/Human Resources (HR) Coordinator initiated a review of employee files for all nursing staff, to ensure current Cardiopulmonary Resuscitation (CPR) certificates, active nursing licenses and SRNA certifications, and the completion of background checks. The audit was completed on 03/03/15.</p> <p>14. On 02/19/15, the Medical Records Coordinator and the RDCS audited fifty (50) residents who expired at the facility during RN #1's employment between 12/04/12 and 02/21/15, to determine if RN #1 had been involved in any other Code Blue events. They found of the fifty (50) deaths, twenty-one (21) occurred while RN #1 was on duty; however, all residents except Resident #1 were a DNR status at the time of death.</p> <p>15. On 02/21/15, while still on suspension, RN #1 called the facility and voluntarily resigned her position of employment with the facility.</p> <p>16. On 02/27/15, the Administrator and the DON informed the Medical Director of the specific citations, and discussed the facility's plan for correction of the deficient practice.</p> <p>17. On 02/27/15, the Administrator and the DON in-serviced the facility's two (2) SSD's, the MDS Nurses and the Medical Records Coordinator</p>	F 281		
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F 291	<p>Continued From page 80</p> <p>related to the facility's new policy and procedure regarding Advance Directives, which includes the following actions: Social Services will review each resident's Advance Directives upon admission to the facility, including their wishes regarding code status, obtain a Physician's Order for the code status, obtain consent from the resident and/or the Power of Attorney (POA), and initiate the Advance Directives Care Plan; the MDS Nurses will audit the initial Care Plans for the presence of Advance Directives within 72 hours of admission, and the Interdisciplinary Care Plan Team will review all residents' Advance Directives during the regularly scheduled Care Plan meetings.</p> <p>18. On 02/27/15 through 03/02/15, all staff from every department, including Nursing, Dietary, Maintenance, Social Services, Activities, and Housekeeping, was In-serviced by the DON, SSD, SDC, QA Officer, and the Nursing Supervisor related to Advance Directives and Residents' Rights. Each staff member was required to complete a post-test with 100% accuracy on the subject matter. Immediate re-education was provided for any incorrect answers.</p> <p>19. Between 02/27/15 and 03/02/15, all nursing staff, including nurses, KMAs and SRNA's were educated by the DON, SSD, SDC, QA Officer and the Nursing Supervisor on the following: differentiation between DNR and Full Code status; how to identify a resident's code status; how to call for and initiate a Code Blue; who should respond to a Code Blue immediately; where to locate the crash cart; contacting the Physician and calling 911; continuation of the code until EMS arrival; notification of the DON</p>	F 281		
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F 281	<p>Continued From page 81 and Administrator; and documentation of all details of the code in the medical record.</p> <p>In addition, the training included how to manage the resident who had a DNR status, including an assessment for vital signs at five (5) minute intervals, pronouncement of death, notification of the Physician, the family and/or POA, and the DON and Administrator, and documentation in the medical record. All participants were required to complete a post-test related to the training with 100% accuracy, with immediate re-education provided for any incorrect answers.</p> <p>20. Between 02/27/15 and 03/02/15, all nurses, KMA and SRNA's were in-serviced regarding the requirement for inclusion of the resident's Advance Directives and code status on the Comprehensive Care Plan. The training was provided by the DON, SDC and Nursing Supervisor. All participants were required to complete a post-test related to the training with 100% accuracy, with immediate re-education provided for any incorrect answers. Two (2) staff members were on leave and did not receive the education. They will not be added to the schedule until they are in-serviced and able to complete the post-test accurately to ensure their competency.</p> <p>21. As of 02/27/15, fifty-six (56) of one hundred and twenty-eight (128) residents had an Advance Directive for Full Code status.</p> <p>22. On 02/28/15, the DON updated the new hire orientation outline to include training and post-tests related to professional nursing standards, identifying code status, Comprehensive Care Plans, Advance Directives,</p>	F 281		

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F 251	<p>Continued From page 82</p> <p>Residents' Rights, Code Blue information sheet, Code Blue Nurses' Note guide, and the facility's Code Blue Protocol. In addition, orientation packets were developed for agency staff to educate on the same topics. All agency staff will be expected to complete the post-tests with 100% accuracy prior to providing direct care.</p> <p>23. Between 02/28/15 and 03/02/15, all nurses, KMAs and SRNA's were in-serviced by the DON, SDC and the Nursing Supervisor related to professional nursing standards. Training references included the Lippincott Manual of Nursing Practice as it pertained to the provision of CPR, documentation, ensuring a Physician's Order for DNR status, and honoring each resident's Advance Directives. All participants were required to complete a post-test related to the training with 100% accuracy, with immediate re-education provided for any incorrect answers.</p> <p>24. On 03/03/15, the facility conducted a mock Code Blue drill to assess staff knowledge retention after training related to initiating a Code Blue event immediately, and evaluated response time, accuracy in determining the code status of the mock resident, and adherence to the facility's policy and procedure. A mock Code Blue drill will be conducted quarterly by the SDC, QA nurse or the DON, and will cover all shifts on weekdays and weekends. Results of the drills will be brought by the Administrator or the DON to the facility QA meetings for interdisciplinary review. Any staff members identified to not follow facility policy and procedures will be re-educated, and a competency test will be administered until the staff member is able to display a thorough and accurate understanding of the policy and procedure.</p>	F 281		
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F 281	<p>Continued From page 53</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> 1. Review of the facility's investigation of the incident revealed SRNA #1, Nursing Supervisor #1 (LPN #1/Supervisor), RN #1 and RN #2 were interviewed related to the Code Blue event involving Resident #1. Continued review of the investigation revealed RN #1 and RN #2 were suspended on 02/18/15, pending the investigation results. Interview, on 03/04/15 at 6:00 PM, with the DON revealed RN #1 called the facility on 02/21/15, and stated she was quitting and would not be returning to work, and hung up. 2. The State Survey Agency received the initial report regarding the delayed Code Blue event involving Resident #1 on 02/18/15. 3. Review of the facility's investigation documentation of the incident revealed the DON notified Resident #1's family of RN #1's delay in initiating a Code Blue. Phone contact was attempted with Resident #1's RP/family which was unsuccessful and a message was left. However, no return call was received. 4. Review of the facility's in-service sign-in form dated 02/18/15 and 02/19/15, revealed 100% of nursing staff did receive training on the facility's Code Blue Protocol, which included education on immediate initiation of CPR, based on Physician's Orders and the individual's Advance Directives and stated wishes regarding their code status, 	F 281		

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F 281	<p>Continued From page #4</p> <p>when a resident was discovered to be without vital signs.</p> <p>Interviews on 03/04/15: at 1:55 PM with LPN #1; at 4:15 PM, with LPN #2; at 3:20 PM, with LPN #3; and at 4:50 PM with RN #4 revealed they were inserviced on the facility's Code Blue procedures, how to identify a resident's code status, when to initiate CPR, and the code process.</p> <p>Interviews on 03/04/15: at 3:49 PM, with SRNA #13, at 4:35 PM with SRNA #6; and at 4:58 PM with SRNA #12 revealed they were inserviced on the facility's Code Blue process, how to identify a resident's code status, call a Code Blue, take crash cart to room and wait for further directions.</p> <p>5. Review of the facility's document titled, "Medical Emergency Code Reference", not dated, revealed the DON had revised the facility's policy and procedure to include the requirement for adding each resident's code status to the care plan.</p> <p>Interviews on 03/04/15 at 5:20 PM, with Social Services (SS) #13, and at 5:30 PM, with SS #2, revealed they were in-serviced related to SS responsibility for implementing an interim Advance Directive care plan to include the code status for all new residents upon admission and/or readmission.</p> <p>Interview on 03/06/15 at 4:50 PM, with the RN #4/MDS Coordinator revealed the MDS nurses were in-serviced related to MDS' responsibility to audit the interim care plan within 72 hours of every resident's admission, and/or readmission, and to assure Advance Directives with code</p>	F 281		
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F 281	<p>Continued From page 85 status were present.</p> <p>6. Interview, on 03/06/15 at 6:30 PM, with the DON revealed she developed a new system for Quarterly Care Plan meetings to discuss with residents and their RP if a change in code status is desired by the resident.</p> <p>Review of the facility's policy titled, "Care Plans" with a revised date of 02/27/15, revealed the Care Plan Team would review with the resident any existing/current Advance Directives to determine if a change in code status was desired by the resident at the Quarterly Care Plan meetings.</p> <p>Interviews, on 03/06/15 at 4:00 PM, with SS #2 and at 4:30 PM with SS #13, revealed Advance Directives including the code status was discussed with each resident at every care plan meeting now.</p> <p>Interview, on 03/06/15 at 4:50 PM, with RN #4/MDS Coordinator, revealed the care plan team did discuss Advance Directives including the code status with the resident or RP at each care plan meeting now.</p> <p>7. Interview, on 03/06/15 at 6:30 PM, with the DON revealed she had developed a Code Blue Information form which was to be attached to Incident Reports for all Code Blue events that were to be turned in to her. The DON revealed she had also developed a reference book for all Code Blue events which were placed with each crash cart. Per the DON, she will submit all investigations to the facility's monthly QA meeting.</p> <p>Observation on 03/06/15 from 3:00 PM through</p>	F 281		

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F 281	<p>Continued From page 86</p> <p>3:20 PM of each crash cart in the facility revealed a reference book for Code Blue events which included the Code Blue documentation form. Review of the facility's Code Blue reference book revealed a form titled, "Code Blue Documentation", dated 02/18/15, which was revised 02/27/15.</p> <p>8. On 03/06/15 at 2:00 PM a call was placed to the Ombudsman with no answer, a message left to return a call. The Ombudsman returned the call and revealed the Administrator did notify her of the delay in initiating a Code Blue for Resident #1, and explained the corrective actions taken by the facility and invited her to participate.</p> <p>Interview with the Administrator on 03/06/15 at 6:15 PM, revealed he had called the Ombudsman on 02/19/15 as per the AOC.</p> <p>9. Interview with the Administrator on 03/06/15 at 6:15 PM, confirmed the facility's Medical Director was contacted by phone for the QA meeting on 02/19/15, to notify him of the delay in providing CPR and to discuss a plan of action.</p> <p>Interview, on 03/06/15 at 3:00 PM, with the facility's Medical Director and Resident #1's attending Physician revealed the Administrator, the DON and the RDCS had called on 02/19/15, to discuss the events which occurred with Resident #1's code on 02/18/15. He stated "we" did put plans into action, and he felt the facility had a very active QA program. The Medical Director revealed the facility had a meeting monthly and he "rarely" missed a meeting.</p> <p>10. Review of the facility's Ad hoc QA meeting sign-in sheet revealed the attendees included the</p>	F 281		
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F 281	<p>Continued From page 87</p> <p>Medical Director, Administrator, DON, QA Nurse, RDCS, RDO, UMs and SDC.</p> <p>Interview, on 03/06/15 at 3:50 PM, with Medical Records (MR) revealed during the QA meeting assignments were made and MR was assigned duties related to the Advance Directives regarding completing a daily audit. Per interview, the audit was for identification/verification of all residents' code status, by ensuring the code status on the residents' door name plate, SRNA care plan, Comprehensive Care Plan, spine of the residents' charts, and inside the front cover of the charts matched the Physician Order. Further interview revealed this was reviewed by the DON/Administrator daily.</p> <p>Interview, on 03/06/15 at 5:25 PM, with the QA Nurse revealed on 02/19/15, a QA meeting was held with the Medical Director, Administrator, DON, Nursing Supervisor, SS, Dietary, Activities Director, Director of Rehabilitation and QA in attendance. Per interview, the QA attendees reviewed and authorized revision of the facility's current code status policy to include each resident's code status on the care plan. The QA Nurse revealed members were assigned specific tasks on the check list which they developed to ensure ongoing compliance. Further interview revealed the QA attendees determined the root cause of CPR provision for Resident #1 was due to RN #1's failure to follow the facility's policies and procedures related to code status and discussed an action plan.</p> <p>Interviews, on 03/06/15 at 4:00 PM, with SS #2, and at 4:30 PM with SS #13, revealed SS was assigned duties related to the new policy and procedure for Advance Directives. Per interview,</p>	F 281		

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F 281	<p>Continued From page 88</p> <p>SS was to obtain consents from the resident or POA, notify the nursing supervisor of the unit the resident was admitted to, and obtain a Physician's Order for the code status decision. Further interview revealed SS will initiate the Advance Directive care plan for residents.</p> <p>Interview on 03/06/15 at 4:50 PM, with RN #4/MDS Coordinator revealed the MDS nurses were assigned duties related to the new policy and procedure for Advance Directives. Per interview, MDS' duties were to audit the interim care plan within 72 hours of every admission, and/or readmission, to assure Advance Directives with code status were present.</p> <p>11. Interview, on 03/06/15 at 3:50 PM, with Medical Records (MR) revealed MR was assigned duties related to Advance Directives to complete a daily audit for identification/verification of all residents' code status by ensuring the code status on the residents' door name plate, SRNA care plan, comprehensive care plan, spine of the chart, and inside the front cover of the chart matched the Physician's Order. Per interview, the audits were turned into the DON/Administrator daily, with the first audit completed on 02/19/15, when MR and the QA Nurse audited 100% of residents' charts for verification of their code status.</p> <p>Interview, on 03/06/15 at 5:25 PM, with the QA Nurse revealed MR and herself completed the daily audit Monday through Friday for identification and verification of all residents' code status by ensuring the code status on the residents' door name plate, SRNA care plan, Comprehensive Care Plan, spine of the chart, and inside the front cover of the chart matched</p>	F 281		
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F 281	<p>Continued From page 89</p> <p>the Physician's Order and the House Supervisor completed the audits on the weekend. Per interview, the audits would continue until the immediate Jeopardy (IJ) was abated.</p> <p>Review of the audits performed by MR and the QA Nurse confirmed completion of the tasks as assigned per the AOC.</p> <p>Interview on 03/06/15 at 6:30 PM, with the DON revealed the code status audits were turned in daily for her review.</p> <p>12. Review of the Central Supply Clerk's (CSC) audit forms (Crash Cart Check List form) revealed the six (6) crash carts was audited daily for expired items and the presence of adequate supplies, with no issues identified beginning 02/19/15.</p> <p>Interview, on 02/24/15 at 8:55 AM, with the CSC revealed he checked the six (6) crash carts daily Monday through Friday, and the House Supervisor checked them on the weekends for expired items and to ensure they were locked. Per Interview, while doing the audit if an item was used from a crash cart the item was replaced and a new breakaway lock would be applied to the cart. The CSC revealed audits continued to be performed.</p> <p>Interview on 03/06/15 at 6:30 PM, with the DON revealed the audit results were reviewed and would be taken to the facility's monthly QA meeting.</p> <p>13. Review of seven (7) employee files on 03/06/15, revealed the employee files were complete with current CPR cards, active nursing</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504		
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F 281	<p>Continued From page 90</p> <p>licenses and SRNA certifications, and background checks.</p> <p>Interview on 03/06/15 at 6:30 PM, with the DON revealed the employee file audits were completed as per the AOC on 03/03/15.</p> <p>14. Review of the audit completed on 02/19/15, revealed fifty (50) residents who had expired in the facility between 12/04/12 and 02/21/15, medical records were audited. Of the fifty (50) deaths, twenty-one (21) were identified to have occurred during the time frame.</p> <p>Interview with MR on 03/06/15 at 3:50 PM, revealed the audits were completed of residents who had expired from 12/04/12 to 02/21/15, the timeframe during which RN #1 was employed. Per interview, twenty-one (21) of the fifty (50) deaths occurred when RN #1 was on duty, however, only Resident #1 had been a Full Code, with the rest having a DNR status.</p> <p>15. Interview, on 03/06/15 at 5:55 PM, with the DON revealed RN #1 had called the facility on 02/21/15, and said she quit and would not be returning to work.</p> <p>16. Interview, on 03/06/15 at 3:00 PM, with the facility's Medical Director revealed the Administrator and DON had informed him of the IJ deficiencies and they discussed the facility's plan for correction for the identified deficiencies.</p> <p>17. Review of the facility's inservice education revealed the two (2) SSD's, MDS Nurses and MR Coordinator were inserviced on 02/27/15, as per the AOC.</p>	F 281		

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F 281	<p>Continued From page 91</p> <p>Interview, on 03/06/15 at 3:50 PM, with MR Coordinator revealed she had received education related to the new policy and procedure for Advance Directives. Per interview, her assigned duties related to the Advance Directives were to complete a daily audit for identification/verification of all residents' code status by ensuring the code status on the residents' door name plate, SRNA care plan, Comprehensive Care Plan, spine of the chart, and inside the front cover of the chart matched the Physician's Order. The MR Coordinator revealed the audits were reviewed by the DON/Administrator daily.</p> <p>Interviews, on 03/06/15 at 4:00 PM, with SS #2 and at 4:30 PM, with SS #13, revealed they had received education on the new policy and procedure for Advance Directives. Per interview, the SS assigned duties related to the new policy and procedure for advance directives were to obtain consents from the Resident/POA, notify the nursing supervisor of the unit the resident was admitted to obtain a Physician's Order for the code status decision. The SS revealed they were to initiate the Advance Directive care plan. Further interview revealed the care plan team reviewed the Advance Directives care plan during regularly scheduled care plan meetings.</p> <p>Interview, on 03/06/15 at 4:50 PM, with RN #4/MDS Coordinator revealed the MDS nurses had received the education on the new policy and procedure for Advance Directives. Per interview, MDS Nurses assigned duties related to the new policy and procedure for Advance Directives was to audit the interim care plan within 72 hours of every admission, and/or readmission, and to assure Advance Directives with code status were present. Further interview revealed the care plan</p>	F 281		

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F 281	<p>Continued From page 92</p> <p>team reviewed the Advance Directives care plan during regularly scheduled care plan meetings.</p> <p>18. Review of the facility's In-service sign in sheet and post-test from 02/27/15 through 03/06/15, revealed all facility staff had received education on the facility's Advance Directives and Residents' Rights with scores of 100%.</p> <p>Interviews on 03/04/15: at 3:18 PM with the Groundskeeper; at 3:20 PM with LPN #8; at 3:33 PM with Laundry personnel #8; at 3:49 PM with SRNA #13; at 4:00 PM with the Dietary Manager; at 4:15 PM with LPN #2/MDS Nurse; at 4:30 PM with SRNA #8; at 4:50 PM with RN #4/MDS Coordinator and SRNA #2; at 4:58 PM with SRNA #12; at 5:05 PM with Dietary Aide #6; at 5:07 PM with the Activities Director; at 5:15 PM with LPN #1/Supervisor; at 5:20 PM with LPN #4; at 5:35 PM with Activities Assistant #10; at 5:48 PM with the Maintenance Supervisor; and at 5:50 PM with SRNA #8/KMA and RN #5; and Interviews on 03/06/15: at 12:35 PM with LPN #10/Weekend Supervisor; at 1:00 PM with SRNA #19 and SRNA #14; at 1:25 PM with Laundry personnel #14; at 1:40 PM with Housekeeper #15; at 2:00 PM with SRNA #15; at 2:06 PM with Dietary Aide #19; at 2:30 PM with SRNA #16/KMA; at 2:40 PM with Administrative Assistant #16; at 3:00 PM with the Dietary Supervisor; at 3:35 PM with SRNA #1; at 3:50 PM with Physical Therapy Assistant (PTA) and SRNA #11; at 4:00 PM with SS #2 and SRNA #10; at 4:05 PM with LPN #9; at 4:25 PM with LPN #3; at 4:30 PM with SS #13; at 4:40 PM with SRNA #9; and at 4:50 PM with RN #6 revealed they had all received In-service education regarding Residents' Rights, Advance Directives and Code Blue events. The staff interviewed revealed they had been post-tested, as per the</p>	F 281		
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F 281	<p>Continued From page 93 AOC.</p> <p>Interview on 03/06/15: at 4:00 PM with SS #2; at 4:30 PM with SS #13; and at 5:30 PM with the SDC, revealed they had all participated in the training of all facility staff on Advance Directives and Residents' Rights, which required a post-test with 100% accuracy, with immediate re-education provided for any incorrect answers.</p> <p>Interview, on 03/06/15 at 5:55 PM, with the DON revealed she had also participated in providing the in-service education for all facility staff regarding Advance Directives and Residents' Rights, which required a post-test with 100% accuracy, with immediate re-education provided for any incorrect answers.</p> <p>19. Review of the facility's in-service sign in sheets and post test for 02/27/15 thru 03/02/15, on 03/06/15, revealed 100% of nursing staff had received education on the facility's code blue protocol which included differentiation between DNR and Full code status; how to identify a resident's code status; who should respond to a code blue immediately; how to call for and initiate a code blue; where to locate the crash cart; contacting the residents physician and calling 9-1-1; continuation of the code until turned over to EMS; notification of the DON and Administrator; and documentation of all details of the code in the medical record.</p> <p>Interviews on 03/04/15: at 3:20 PM with LPN #8; at 3:49 PM with SRNA #13; at 4:15 PM with LPN #2/MDS Nurse; at 4:30 PM with SRNA #6; at 4:50 PM with RN #4/MDS Coordinator and SRNA #2; at 4:58 PM with SRNA #12; at 5:15 PM with LPN #1/Supervisor; at 5:20 PM with LPN #4; and at</p>	F 281		
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5:50 PM with SRNA #8/KMA and RN #5; and interviews on 03/08/15: at 12:35 PM with LPN #10/Weekend Supervisor; at 1:00 PM with SRNA #19 and SRNA #14; at 2:00 PM with SRNA #15; at 2:30 PM with SRNA #16/KMA; at 3:35 PM with SRNA #1; at 3:50 PM with SRNA #11; at 4:00 PM with SRNA #10; at 4:05 PM with LPN #9; at 4:25 PM with LPN #3; at 4:40 PM with SRNA #9; and at 4:50 PM with RN #6 revealed they had all received in-service education regarding differentiation of DNR and Full Code status, how to identify a resident's code status, how to call for and initiate a Code Blue, who should respond to a Code Blue immediately, where to locate the crash carts, contacting the Physician and calling 911, continuation of a code until EMS arrived, notification of the DON and Administrator, and documentation of all details of the code in the medical record. Additionally, the staff interviewed revealed they had also been educated on how to manage a resident who had a DNR status, and had to take a post-test and score 100%.

Interview on 03/06/15: at 4:00 PM with SS #2; at 4:30 PM with SS #13; and at 5:30 PM with the SDC, revealed they had all participated in the training of all facility nursing staff on the facility's Code Blue policy and procedure, protocol and process to manage a resident with a DNR status, verify no vital signs at five minute intervals, pronouncement of death and notification of Physician, family/POA, DON, and Administrator and documentation in the medical record, which required a post-test with 100% accuracy, with immediate re-education provided for any incorrect answers.

Interview, on 03/08/15 at 5:55 PM, with the DON revealed she had participated in the training of all

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nursing staff on the facility's Code Blue policy and procedure, protocol, and process to manage a resident with a DNR status, verify no vital signs at five minute intervals, pronouncement of death and notification Physician, family/POA, DON, and Administrator and documentation in the medical record. Per interview, each area required a post-test with 100% accuracy, with immediate re-education provided for any incorrect answers. The DON further stated two (2) staff members were out on leave and did not receive the training; however, would not be added to the schedule until they were in-serviced and completed the post-test with 100 % accuracy.

20. Review of the facility's in-service sign in sheets and post test on 03/06/15, for 02/27/15 through 03/02/15, revealed nursing staff (Nurses, KMAs and SRNA's) had received education on the facility's requirement for inclusion of the resident's Advanced Directives and code status on the Comprehensive Care Plan.

Interviews on 03/04/15: at 3:20 PM with LPN #8; at 3:49 PM with SRNA #13; at 4:15 PM with LPN #2/MDS Nurse; at 4:30 PM with SRNA #6; at 4:50 PM with RN #4/MDS Coordinator and SRNA #2; at 4:58 PM with SRNA #12; at 5:15 PM with LPN #1/Supervisor; at 5:20 PM with LPN #4; and at 5:50 PM with SRNA #8/KMA and RN #5; and Interviews on 03/06/15: at 12:35 PM with LPN #10/Weekend Supervisor; at 1:00 PM with SRNA #19 and SRNA #14; at 2:00 PM with SRNA #15; at 2:30 PM with SRNA #18/KMA; at 3:35 PM with SRNA #1; at 3:50 PM with SRNA #11; at 4:00 PM with SRNA #10; at 4:05 PM with LPN #9; at 4:25 PM with LPN #3; at 4:40 PM with SRNA #9; and at 4:50 PM with RN #8 revealed they had all received in-service education regarding the

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requirement for inclusion of a resident's Advance Directives and code status on the Comprehensive Care Plan. Additionally, the staff interviewed revealed they all had taken a post-test and had to score 100%.

Interview with the SDC on 03/06/15 at 5:30 PM, revealed she had participated in the training of all nursing staff on the facility's requirement for inclusion of the resident's Advance Directives and code status on the Comprehensive Care Plan. Per interview, a post-test was required with 100% accuracy, with immediate re-education provided for any incorrect answers.

Interview, on 03/06/15 at 5:55 PM and 6:30 PM, with the DON revealed she had participated in the training of all staff on the facility's requirement for inclusion of the resident's Advance Directives and code status on the Comprehensive Care Plan. Per interview, a post-test was required with 100% accuracy, with immediate re-education provided for any incorrect answers. Further interview revealed two (2) staff members were out on leave and did not receive the training; however, would receive the training prior to being added to the schedule, and would have to complete the post-test as required, but will not be added to the schedule until they are in-serviced and complete the post-test accurately.

21. Review on 03/06/15, of the 02/27/15 code status audits revealed fifty-six (56) of one hundred and twenty-eight (128) residents had a Full Code status as per their Advance Directives.

Interview with MR on 03/06/15 at 3:50 PM, revealed she and the QA Nurse had audited all residents' records on 02/27/15, and fifty-six (56)

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F 281	<p>Continued From page 97</p> <p>of those residents' records had an Advance Directive for Full Code status.</p> <p>22. Interview, on 03/06/15 at 5:30 PM, with the SDC revealed the new hire orientation packet did include the new training and post-test related to professional nursing standards, Comprehensive Care Plans, Advance Directives, Identifying code status, facility's Code Blue protocol and new Code Blue forms. Per interview, the post-test would be required with a 100% accuracy, and immediate re-education provided for any incorrect answers.</p> <p>Interview, on 03/06/15 at 6:30 PM, with the DON revealed all agency staff received orientation packets to educate them on the same topics as facility staff. Per interview, all agency staff would complete the post-test with 100% accuracy prior to providing direct care.</p> <p>Interview, on 03/06/15 at 1:00 PM, with RN #7, an agency nurse, revealed she did receive the facility's in-service training and had completed a post-test for each topic regarding the facility's protocol for Advance Directives, code status, Comprehensive Care Plan, Resident Rights, and Code Blue documentation forms.</p> <p>23. On 03/06/15, review of the facility's in-service sign in sheets and post test for 02/28/15 through 03/02/15, revealed nursing staff (Nurses, KMAs and SRNA's) did received education related to professional nursing standards, pertaining to provision of CPR, documentation, ensuring a Physician's order for DNR status and honoring each resident's Advance Directives.</p> <p>Interviews on 03/04/15: at 3:20 PM with LPN #8;</p>	F 281		
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F 281	<p>Continued From page 98</p> <p>at 3:49 PM with SRNA #13; at 4:15 PM with LPN #2/MDS Nurse; at 4:30 PM with SRNA #6; at 4:50 PM with RN #4/MDS Coordinator and SRNA #2; at 4:58 PM with SRNA #12; at 5:15 PM with LPN #1/Supervisor; at 5:20 PM with LPN #4; and at 5:50 PM with SRNA #8/KMA and RN #5; and interviews on 03/09/15: at 12:35 PM with LPN #10/Weekend Supervisor; at 1:00 PM with SRNA #19 and SRNA #14; at 2:00 PM with SRNA #15; at 2:30 PM with SRNA #16/KMA; at 3:35 PM with SRNA #1; at 3:50 PM with SRNA #11; at 4:00 PM with SRNA #10; at 4:05 PM with LPN #9; at 4:25 PM with LPN #3; at 4:40 PM with SRNA #9; and at 4:50 PM with RN #6 revealed they had all received in-service education regarding professional nursing standards which pertained to provision of CPR, documentation, ensuring a Physician's Order for a DNR status and honoring a resident's Advance Directives. Additionally, the staff interviewed revealed they all had taken a post-test and had to score 100%.</p> <p>24. Review of the 03/03/15 Mock Code Blue sign-in sheet revealed seven (7) LPN's, one (1) RN, five (5) SRNA's and MR responded to the Mock Code Blue drill. Review of the Incident/Accident form, Nurse's Note, Code Blue Information form, and Code Blue Nurse's Notes Guide revealed the staff responded timely, and followed the facility's protocol for a Code Blue.</p> <p>Interviews, on 03/06/15 at 1:30 PM, with SRNA #2, at 2:10 PM, with SRNA #18, revealed they had participated in the mock Code Blue on 03/03/15. SRNA #2 and SRNA #18 stated the drill went very well, and everyone seemed to be more comfortable with their role in a Code Blue event.</p>	F 281		
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F 281	<p>Continued From page 99</p> <p>Interview, on 03/06/15 at 1:45 PM, with LPN #1/Supervisor revealed she had taken the lead in the mock Code Blue, and after assessing the mock resident for vital signs had given the order to page a Code Blue. Per interview, she informed those present to get the crash cart, and CPR was initiated timely and documentation was completed. She further stated she felt good about the mock Code Blue.</p> <p>Interview, on 03/06/15 at 5:30 PM, with the SDC revealed a mock Code Blue drill would be completed quarterly on all shifts and on weekends.</p>	F 281		
F 309 SS=J	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and procedures, facility's investigation report, and the Emergency Medical Services (EMS) report, it was determined the facility failed to have an effective system to ensure one (1) of eight (8) sampled residents (Resident #1) received Cardiopulmonary Resuscitation (CPR) according to established professional standards to promote the highest</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504
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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) COMPLETION DATE
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F 309 Continued From page 100
practicable physical well-being of residents regarding their advance directives and code status.

Resident #1 had Advance Directives, dated 09/11/12, requesting life-saving measures be instituted in the event of cardiac or respiratory failure, to include CPR. On 02/18/15 at approximately 8:30 AM, Resident #1 was found unresponsive by State Registered Nursing Assistant (SRNA) #1 who immediately notified Registered Nurse (RN) #1 of this information. However, after assessing Resident #1 for a pulse and not finding any, RN #1 failed to immediately initiate CPR for this resident. SRNA #1 then informed RN #2 of Resident #1 being unresponsive, who went to the resident's room without checking his/her code status. RN #2 asked RN #1 what the resident's code status was, and RN #1 told her it was a Full Code. Even though RN #2 was informed of this information and told RN #1 they needed to initiate CPR, the nurses failed to honor Resident #1's request for CPR provision.

RN #2 overhead paged Licensed Practical Nurse (LPN) #1/Supervisor who entered Resident #1's room at approximately 9:00 AM, an observed neither RN was performing CPR. LPN #1/Supervisor told the RNs Resident #1 was a Full Code and CPR had to be initiated. However, LPN #1/Supervisor failed to ensure RN #1 and RN #2 initiated CPR, and left the resident's room to call LPN #2/MDS Nurse to verify providing CPR for Resident #1. At approximately 9:05 AM, LPN #2/MDS Nurse and RN #4/MDS Coordinator went to Resident #1's room where CPR had still not been initiated. CPR was initiated per interview at approximately 9:05 AM to 9:10 AM.

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F 309	<p>Continued From page 101</p> <p>thirty-five (35) to forty (40) minutes after the resident was found unresponsive, 911 was called, and Resident #1 was transported to the hospital Emergency Room (ER) where the resident was pronounced deceased at 9:38 AM.</p> <p>The facility's failure to provide the necessary care and services related to the resident's requested Full Code status and the provision of CPR, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/28/15, and was determined to exist on 02/18/15. The facility was notified of the Immediate Jeopardy on 02/26/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/04/15 with the facility alleging removal of the Immediate Jeopardy on 03/04/15. Immediate Jeopardy was verified to be removed on 03/04/15 as alleged by the State Survey Agency prior to exit on 03/06/15, with remaining non-compliance at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's "Medical Emergency Code Reference", undated, revealed a "Code Blue" might be called anytime a resident was determined to have a life threatening medical condition. Per the "Medical Emergency Code Reference", the "Code Blue" could be initiated by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), who were to "overhead page" three (3) times the room number or location of the "Code Blue", all available nursing staff were to</p>	F 309			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1806 VERSAILLES ROAD LEXINGTON, KY 40504
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F 309	<p>Continued From page 102</p> <p>respond, staff were to the "check code status" of the resident, initiate Cardiopulmonary Resuscitation (CPR) if appropriate, contact the Physician and/or "send out 911" and "document all details of the code in the medical record".</p> <p>Review of the facility's policy titled, "Cardiopulmonary Resuscitation (CPR)", undated, revealed the purpose was to ventilate and establish circulation on a resident with absence of respirations and pulse. Per the Policy, as specific procedures for CPR were revised frequently, the procedure was to be verified with the American Heart Association and/or the American Red Cross in the area. Continued review revealed staff was to do the following: if a resident was unresponsive call for help; check the resident's code status and if he/she was a Full Code staff was to call "paramedics" (911); delegate someone to "take notes" on when the resident was found unresponsive, the time CPR was initiated, who provided chest compressions and ventilations; continue CPR until help arrived; and, document the "entire event" in the resident's medical record.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 06/22/12, and re-admitted him/her on 09/05/14, with diagnoses which included Acute Respiratory Failure, Chronic Airway Obstruction, Unspecified Chronic Ischemic Heart Disease, and Unspecified Chronic Bronchitis. Review of the Quarterly MDS dated 12/07/14, revealed the facility assessed Resident #1 as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15). Review of the Advance Directives, dated 09/11/12 and signed by Resident #1, revealed the resident requested to have a Full Code status which included CPR in the event of</p>	F 309		
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F 309	<p>Continued From page 103</p> <p>non-responsiveness. Review of the February 2015 monthly Physician's Order revealed an order for Resident #1 to be a Full Code.</p> <p>However, review of a Nurse's Note 02/18/15 at 8:40 AM, RN #1 was called to Resident #1's room by State Registered Nursing Assistant (SRNA) #1 who told her the resident "don't look too good". Per the Note, RN #1 observed Resident #1 lying on the bed, she shook the resident with "no response", and checked for a pulse with none found and he/she had "no respirations". Even though RN #1's documentation noted this, there was no documented evidence she immediately initiated CPR, had a "Code Blue" paged overhead three (3) times, or contacted the Physician or 911, as per the facility's "Medical Emergency Code Reference". RN #1 documented she called for "assist" from a nurse on another wing, who arrived and CPR was then initiated and 911 called. Continued review revealed RN #1 noted at 9:10 AM, "911 here" who placed Automated External Defibrillator (AED) pads on the resident with no pulse obtained and the Emergency Medical Services (EMS) staff placed Resident #1 on a "backboard" and continued CPR.</p> <p>Review of a Nurse's Note dated 02/18/15 at 9:00 AM, documented by LPN #1/Supervisor revealed she was "overhead paged" to "call" the nurse's station on the unit Resident #1 resided, which she did and was told Resident #1 was "dead". LPN #1 documented she went to Resident #1's room and CPR was initiated. Continued review revealed at 9:05 AM, LPN #1 documented 911 was called and CPR continued until EMS arrived, and at 9:15 AM she noted EMS arrived and took over CPR.</p>	F 309			

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F 309	<p>Continued From page 104</p> <p>Review of the EMS Run Sheet dated 02/18/15, revealed the call from the facility was received at 9:08:54 AM, EMS personnel were enroute at 9:08:03 AM, "at the scene" at 9:12:51 AM, with the "patient" (Resident #1) at 9:13:14, departed the facility with the "patient" at 9:22:16 AM and arrived at the hospital ER at 9:29:37 AM. Per the EMS Run Sheet, Resident #1's chief complaint was "cardiac arrest/death", no vital signs were assessed, the resident's pupils were fixed, skin color was pale, and skin temperature was cool.</p> <p>Review of the hospital ER record revealed Resident #1 arrived via ambulance and was triaged at 9:33 AM. Per the record, Resident #1 was reportedly last seen responsive at 8:30 AM by staff of the facility, and the resident presented in "cardio-pulmonary arrest" to the ER. Continued review revealed CPR was in progress on arrival to the ER, and after "multiple rounds" of epinephrine (a medication used to to reverse cardiac arrest) the resident remained in asystole (no heart rate) and was pronounced deceased at 9:38 AM.</p> <p>Further review of a Nurse's Note dated 02/18/15 timed 8:45 AM, for Resident #1, with no nurse's signature, revealed nursing found Resident #1 unresponsive, with no pulse assessed by nursing. Continued review of the Note revealed CPR was initiated by RN #1 and RN #2 with CPR continuing until "911 arrived" at 9:15 AM. Further review of a Note timed 9:30 AM, revealed "called report" to the hospital. In addition, review of a Note timed 10:20 AM, revealed Resident #1 had "passed" per the hospital. However, further record review revealed no documented evidence all details of the code for Resident #1 were recorded to include staff having overhead paged</p>	F 309		

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the "Code Blue" three (3) times, contacted the Physician, the time CPR was initiated, who provided chest compressions, and ventilations, as per the facility's policy.

Review of the facility's "Long Term Care Facility--Self-Reported Incident Form" and investigation attachment dated 02/18/15, revealed it was the facility's "Initial Report" and "5 Day Follow up/Final Report" of an incident which occurred on 02/18/15. Review of the Form revealed the facility had investigated an allegation of neglect involving Resident #1, which was "in progress" related to "RN's response" to finding the resident with "no signs of life and if her actions were timely". According to the investigation information SRNA #1 found Resident #1 non-responsive at approximately 8:45 AM on 02/18/15, and notified RN #1. Per the investigation information the facility determined RN #1 "due to her emotional state over" Resident #1 expiring had not respected the resident's Advance Directives "by initiating a Full Code" and had other nurses in the facility initiate CPR until Emergency Medical Services (EMS) arrived. Continued review of the Form and attachment revealed Resident #1 had "selected" wanting to be a Full Code which was "indicated by" his/her signature and in the medical record. Review of the Form revealed RN #1 and RN #2 were suspended pending the investigation outcome. Review of the investigation documentation revealed witness statements were obtained from SRNA #1, LPN #1, LPN #2, RN #1, RN #2, and RN #4 which were signed and dated.

Review of the facility's investigation revealed SRNA #1's written statement, dated 02/18/15 at 3:00 PM, which noted when she entered Resident

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		B. WING _____	03/06/2015

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#1's room after breakfast "she looked at him and felt that he was dead". Per SRNA #1's written statement, she immediately went to the nursing station and "got" RN #1 to come to the resident's room. Further review revealed "CPR was initiated within five (5) minutes".

Interview with SRNA #1 on 02/24/15 at 10:45 AM, revealed she found Resident #1 in bed unresponsive at approximately 8:30 AM on 02/18/15. SRNA #1 revealed she left Resident #1's room and immediately notified RN #1, and they both returned to the resident's room. Per interview, RN #1 assessed Resident #1 and "saw" that the resident was not breathing and started crying. SRNA #1 revealed she went to another unit and got RN #2 who came to Resident #1's room. SRNA #1 stated she asked the two RNs if they wanted her to get the "crash cart", but RN #2 said "we have it under control". However, per interview, CPR was not started until LPN #1/Supervisor entered the room and said CPR had to be initiated which was approximately ten (10) minutes after she had found Resident #1 non-responsive.

Review of the facility's investigation report revealed RN #1's written statement, dated 02/18/15 at 3:25 PM and documented by the Director of Nursing (DON), revealed SRNA #1 had come to her at "about 8:45 AM", and said she needed to come and see Resident #1. RN #1 revealed she went to Resident #1's room, shook him/her and checked for a carotid, apical and radial pulse, but the resident did not have any. Per RN #1's written statement, she assessed Resident #1's vital signs and "there were none", so she sent SRNA #1 to get a nurse from another unit, and RN #2 arrived in approximately one (1)

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minute. Continued interview revealed she knew that a white label on the spine of a resident's medical record indicated the resident was a Full Code. However, she did not know "why she did not call the code". Further review of RN #1's written statement revealed CPR was not initiated until LPN #1/Supervisor came to the room and told her and RN #2 to "code" Resident #1. In addition, review revealed RN #1 stated she initially "could not do this to" Resident #1, but did "code" the resident as told to by LPN #1/Supervisor, and RN #1 believed CPR was "started within five (5) minutes".

Interview with RN #1 was attempted on 02/24/15 at 1:06 PM, 2:00 PM, 4:30 PM and 5:15 PM, and on 02/25/15 at 10:10 AM with no success.

Review of the facility's investigation report revealed RN #2's written statement, dated 02/18/15 at 3:20 PM documented by the DON, revealed SRNA #1 came to her unit and said RN #1 needed her. RN#2's written statement revealed when she arrived at Resident #1's room, she found RN #1 sitting on the bedside crying. Per the written statement, RN #2 checked Resident #1's pupils and checked for pulses and there were none. Continued review revealed RN #2 told the DON she asked RN#1 if Resident #1 was a DNR or a Full Code, and RN #1 replied a Full Code. RN #2's written statement revealed RN #1 told her she was not going to put Resident #1 "through it" (CPR). Further review revealed RN #2 reported she then notified LPN #1/Supervisor to get her opinion and CPR was initiated and performed for "a good while".

Interview with RN #2 on 02/24/15 at 12:25 AM and 02/25/15 at 11:30 AM, revealed SRNA #1

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came to get her to come to Resident #1's room at approximately 8:35 AM on 02/18/15. RN #2 revealed she did not know Resident #1's code status upon entering the room; however, was informed by RN #1 he/she was a Full Code, but she (RN #1) was not going to put the resident "through that". Per interview, RN #2 should have started CPR when she first entered the room, but felt she did not have any help, because RN #1 refused to do CPR on Resident #1. RN #2 stated she did not know how long it took to start "the code" (CPR), because she did not look at the clock and did not have her watch on that day. Continued interview revealed CPR was not initiated until LPN #1/Supervisor entered the room and instructed her and RN #1 to initiate CPR. RN #2 revealed LPN #2/MDS Nurse documented the code information after CPR was initiated.

Review of the facility's investigation report revealed LPN #1/Supervisor's written statement, dated 02/18/15 with no time noted, revealed at approximately 9:00 AM that morning (about thirty (30) minutes after SRNA #1 had found Resident #1 unresponsive) she was overhead paged by RN #2 to call the A unit where Resident #1 resided. LPN #1/Supervisor's written statement revealed when she called the unit she was informed by RN#2 that Resident #1 "was dead" and she needed to "get up here". Continued review revealed LPN #1/Supervisor went to the unit where she observed Resident #1's chart with a white label indicating the resident was a Full Code; however, when she entered the resident's room she saw RN #1 sitting on the resident's bed patting his/her shoulder. LPN #1/Supervisor's written statement revealed she asked why CPR had not been initiated and RN#1 told her she

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F 309	<p>Continued From page 109</p> <p>could not do that to the resident as he/she would not want it. Per the written statement, LPN #1 told RN #1 the resident was a Full Code, she had to start CPR, and then she went to call LPN #2/MDS Nurse for clarification of Initiating CPR for residents with a Full Code status. Further review revealed RN#2 ran and got the crash cart, CPR was initiated and 911 called.</p> <p>Interview with LPN #1/Supervisor on 02/24/15 at 12:05 PM, revealed it was approximately 9:00 AM when she arrived at Resident #1's room after being overhead paged by RN #2. Per interview, when she arrived in the resident's room, she told RN #1 and RN #2 that CPR had to be initiated and 911 notified. LPN #1/Supervisor revealed the "code" was not performed timely, and CPR should have been initiated immediately after RN #1 assessed Resident #1 and saw he/she was not breathing and had no pulse.</p> <p>Review of the facility's investigation report of LPN #2/MDS Nurse's written statement, dated 02/19/15 at 1:45 PM documented by the DON, revealed LPN #1/Supervisor had called the MDS office on 02/18/15, to "double check code policy" and she told LPN #1/Supervisor she was right. Per the written statement, she went to Resident #1's room where she observed RN #1 at the left side of the head of the resident's bed with RN #2 on the right side; however, LPN #2/MDS Nurse had to tell the two (2) RNs to start CPR. Review revealed RN #1 and RN #2 told her Resident #1 had been found unresponsive at about 8:45 AM. Continued review revealed LPN #2/MDS Nurse observed RN #1 to have tears in her eyes, and the RN told her she "didn't want to have to do CPR on" Resident #1. LPN #2/MDS Nurse's written statement revealed she told RN #1 they</p>	F 309			

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F 309	<p>Continued From page 110</p> <p>had to do CPR because the resident was a Full Code. Further review revealed CPR was then initiated and RN #2 stated "someone needs to be charting this", so LPN #2/MDS Nurse went to the nurse's station and someone gave her a Nurse's Note. In addition, the written statement revealed when the "Paramedics" arrived they asked how long Resident #1 had been like this, and one (1) of the RNs told the "Paramedics" the resident was found at 8:45 AM. Per the written statement, the "Paramedics" inquired if the resident had been "like this twenty (20) minutes" as it was now 9:05 AM.</p> <p>Interview with LPN #2/MDS Nurse on 02/24/15 at 2:40 PM revealed LPN #1 called the MDS office at approximately 9:00 AM to 9:05 AM and asked if a resident was a Full Code and found unresponsive with no pulse if CPR was initiated anyway. LPN #2/MDS Nurse revealed she told LPN #1, "yes CPR had to be initiated", and she went immediately to Resident #1's room. Per interview, when she entered Resident #1's room RN #1 was holding the Ambu Bag (a hand-held device commonly used to provide positive pressure ventilation to patients not breathing or not breathing adequately), and RN #2 was on the opposite side of the bed with the crash cart. Continued interview revealed LPN #2/MDS Nurse told the two (2) RNs to hook up the oxygen to the Ambu Bag and start CPR. LPN #2/MDS Nurse stated RN #1 was "emotional" and told her "she did not want to do that to" Resident #1. Further interview revealed LPN #2/MDS Nurse explained to RN #1, Resident #1 was a Full Code and CPR had to be initiated. Per LPN #2/MDS Nurse the two (2) RNs told her Resident #1 had been found unresponsive at about 8:45 AM. LPN #2/MDS Nurse stated CPR started at approximately 9:10</p>	F 309		
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F 309	<p>Continued From page 111</p> <p>AM (approximately twenty-five minutes after the resident was found unresponsive), LPN #1/Supervisor went and called 911, and EMS arrived at approximately 9:15 AM.</p> <p>Review of the facility's investigation report of RN #4/MDS Coordinator's written statement, dated 02/19/15 at 1:30 PM documented by the DON, revealed LPN #1/Supervisor called the MDS office on 02/18/15 to "say that nurse was not coding" Resident #1, and she thought they should be. Per the written statement, LPN #2/MDS Nurse who spoke to LPN #1/Supervisor told the Supervisor she was correct. Continued review revealed LPN #2/MDS Nurse and RN #4/MDS Coordinator went to Resident #1's room where they observed RN #1 holding the Ambu Bag and RN #2 was on the other side of the resident's bed. RN #4/MDS Coordinator's written statement revealed she told the two (2) RNs they had to put Resident #1's head of bed flat, which was done, and then LPN #2/MDS Nurse told RN #1 and RN #2 they had to start CPR, and it was then initiated. Further review of the written statement revealed RN #4/MDS Coordinator was unable to recall the specific time; however, knew "it was after 9:00 AM".</p> <p>Interview with RN #4/MDS Coordinator on 02/24/15 at 3:00 PM, revealed at approximately 9:00 AM on 02/18/15, LPN #1/Supervisor called the MDS office to verify with LPN #2/MDS Nurse, if CPR had to be initiated if a resident was "lifeless", but was a Full Code. RN #4 revealed LPN #2/MDS Nurse told LPN #1/Supervisor that "yes, it (CPR) had to be done". Per interview, RN #4/MDS Coordinator LPN #2/MDS Nurse went to Resident #1's room and saw RN #1 holding the Ambu Bag and RN #2 on the opposite side of the</p>	F 309		

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F 309	<p>Continued From page 112</p> <p>bed with the crash cart. RN #4 revealed she did not observe any chest compression being done at that time, and could not recall for sure if the Ambu Bag was being utilized. Further interview revealed EMS had been notified, so she left the room to wait for their arrival, and when EMS arrived she did not look at the clock for the exact arrival time.</p> <p>Interview with the Director of Nursing (DON), on 2/24/15 at approximately 2:00 PM and on 02/26/15 at 6:05 PM, revealed if a resident was found not breathing, the nurse should assess the resident and if no pulse or breathing, check for the resident's code status, then start CPR immediately for residents who were a Full Code. Per the DON, the facility utilized a "dot" system to indicate a resident's code status outside the room doors. She stated for residents who were a Full Code a dot was not placed by the door, and if a resident was a DNR status a red dot was placed by their door. The DON stated for residents who were a Full Code a white strip of tape was placed on the spine of the resident's medical record, and a strip of red was used on the records of those who were a DNR status. According to the DON, a Code Blue should be announced overhead three (3) times with the resident's room number, 911 should be called, and CPR should continue until EMS arrived and took over. The DON revealed for Resident #1 CPR was not started immediately; however, should have been.</p> <p>Interview with the Staff Development Coordinator (SDC), on 03/06/15 at 5:30 PM, revealed she had conducted one (1) mock code blue drill early in 2014. The SDC stated she had planned to continue to conduct the drills every three (3) months; however, she did not follow through with</p>	F 309		

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F 309	<p>Continued From page 113</p> <p>her plan and no further drills were conducted prior to the incident on 02/18/15.</p> <p>Continued interview with the DON, on 2/24/15 at approximately 2:00 PM and on 02/26/15 at 6:05 PM, revealed when she interviewed RN #1 after the incident, RN #1 showed "no remorse" and said she "just didn't want to do that to" him/her. Per interview, RN #1 and RN #2 were suspended pending the facility's investigation, and on 02/21/15 RN #1 telephoned the facility and terminated her employment. Further interview with the DON revealed the facility reported RN #1 to the Kentucky Board of Nursing.</p> <p>Interview with the Administrator on 2/26/15 at 3:45 PM revealed, if a SRNA found the resident unresponsive a nurse should be notified immediately. Per interview, the resident's code status should be verified and the resident assessed. Continued interview revealed if the resident was a Full Code, CPR should be initiated immediately and continued until EMS arrived and took over. The Administrator revealed RN #1 did not act appropriately as it related to the facility's policies and procedures. He stated RN #1 told him she knew what the facility's policies and procedures were and knew she should have followed them; however, she did not believe it was what Resident #1 would have wanted. Per the Administrator, RN #1 should have followed the facility's policy.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/03/15, that alleged removal of the IJ effective 03/04/15. Review of the AOC revealed the facility implemented the following:</p>	F 309		

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F 309	Continued From page 114 1. On 02/18/15, the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) interviewed State Registered Nursing Assistant (SRNA) #1, Nursing Supervisor (NS) #1 (LPN #1/Supervisor), RN #1 and RN #2 regarding delay of the Code Blue event involving Resident #1. RN #1 and RN #2 were suspended on 02/18/15 pending the facility's investigation. 2. On 02/18/15, an initial report of the delayed Code Blue event was sent to the State Agency by the Administrator and the DON. 3. On 02/18/15, the DON notified Resident #1's family of the delay in initiating a Code Blue by RN #1. 4. On 02/18/15, the Staff Development Coordinator (SDC) initiated in-services with licensed nurses regarding immediate implementation of the facility's Code Blue Protocol for residents who had Advance Directives which indicated a Full Code status. Immediate training included face-to-face in-services with licensed staff on duty, and instruction by telephone for other licensed staff. On 02/19/15, the training was extended to include SRNA's and Kentucky Medication Aides (KMAs), and 100% of the nursing staff received the education. Training points included the immediate initiation of CPR, based on the Physician's Orders and the individual's Advance Directives and stated wishes regarding their code status, when a resident was discovered to be without vital signs. Utilized for the training was the facility's Code Blue Protocol.	F 309			

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F 309	<p>Continued From page 115</p> <p>5. On 02/19/15, the DON revised the facility's policy and procedure related to code status to include a requirement for adding each resident's code status to the care plan.</p> <p>6. On 02/19/15, the DON developed a new system of quarterly care plan meetings with the resident and/or their Responsible Party (RP), the Social Worker, the unit nurse and the MDS nurse, to determine if any change in code status is desired by the resident.</p> <p>7. On 02/19/15, the DON developed a Code Blue information form to be attached to the incident report for all Code Blue events. Both forms are turned in to the DON for further investigation. The DON will submit results of all investigations to the monthly QA meetings. In addition, the DON developed a reference book for Code Blue events, and placed a book on each crash cart.</p> <p>8. On 02/19/15, the Administrator notified the Ombudsman of the delay in initiating a Code Blue for Resident #1. The Administrator explained the corrective actions taken by the facility, and invited the Ombudsman to participate in the investigation process.</p> <p>9. On 02/19/15, a Quality Assurance (QA) meeting was held by telephone conference. Participants included the Administrator, the DON, and the Medical Director, who was also the Attending Physician for Resident #1. The purpose of the meeting was to notify the Medical Director of the delay in providing CPR for Resident #1, and to discuss corrective actions.</p> <p>10. On 02/19/15, an Ad Hoc QA meeting was held to establish corrective actions and monitoring to</p>	F 309			

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F 309	Continued From page 116 ensure future compliance related to the following: Code Blue response; residents' rights; and the facility's Abuse Policy. Attendees included the Administrator, DON, Medical Director, QA Nurse, RDCS, Regional Director of Operations (RDO), Unit Managers (UMs), and the SDC. The committee reviewed and authorized revision of the facility's current policy related to code status to include code status in each resident's Comprehensive Care Plan. In addition, the committee developed a checklist of items to be completed to ensure no other resident had the possibility of being affected by the deficient practice. Furthermore, the committee assigned individual members of the interdisciplinary team to carry out specific tasks stated on the check list, as well as, actions to ensure ongoing compliance. The committee determined the root cause of the delay in provision of CPR for Resident #1 was due to RN #1's failure to follow the facility's policy and procedure related to code status. Also, on 02/19/15, the regular monthly QA meeting was held and attended by the Administrator, DON, Medical Director, Social Services Director (SSD), QA Officer, Nursing Supervisor, Activities Director (AD), Director of Rehabilitation, Consultant Dietician, and the Dietary Manager Assistant. Participants confirmed the Ad Hoc meeting determination of the root cause and further discussed the facility's plan of action going forward. 11. On 02/19/15, the Medical Records Coordinator and the QA Nurse audited 100% of the 128 residents' charts to verify each resident's code status was correctly identified, and to ensure Physician Orders, Comprehensive Care Plans, and SRNA Care Plans were consistent for	F 309			

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F 309	<p>Continued From page 117</p> <p>either Full Code or DNR status. Each resident's chart holds an identifying sticker on the outside spine to communicate the code status: a white sticker indicates a Full Code status, and a red sticker indicates DNR status. The Medical Records Coordinator updated each resident's Care Plan to reflect individual code status to be either Full Code or DNR. The QA Nurse and the Medical Records Coordinator will continue the audits daily Monday through Friday, and the House Supervisor will perform the audits on the weekends, until the IJ is removed. Audit results will be submitted daily for review by the DON, who will forward the data to the monthly QA meetings for interdisciplinary review.</p> <p>12. On 02/19/15, the Central Supply clerk audited the facility's six (6) crash carts, utilized for managing a Code Blue event, for the presence of adequate supplies, and to ensure no expired items were located on the carts. The crash carts will be checked daily, Monday through Friday by the Central Supply Clerk, and by the House Supervisor on weekends, until the IJ is removed. The audits will utilize the Crash Cart check List Form, and all results will be submitted to the Administrator and the DON for their review. Subsequently, audit results will be presented at the monthly QA meeting, where any changes to the frequency of audits, or recommendations for further interventions, will be made.</p> <p>13. Beginning 02/19/15, the Payroll/Human Resources (HR) Coordinator initiated a review of employee files for all nursing staff, to ensure current Cardiopulmonary Resuscitation (CPR) certificates, active nursing licenses and SRNA certifications, and the completion of background checks. The audit was completed on 03/03/15.</p>	F 309			

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F 309	<p>Continued From page 118</p> <p>14. On 02/19/15, the Medical Records Coordinator and the RDCS audited fifty (50) residents who expired at the facility during RN #1's employment between 12/04/12 and 02/21/15, to determine if RN #1 had been involved in any other Code Blue events. They found of the fifty (50) deaths, twenty-one (21) occurred while RN #1 was on duty; however, all residents except Resident #1 were a DNR status at the time of death.</p> <p>15. On 02/21/15, while still on suspension, RN #1 called the facility and voluntarily resigned her position of employment with the facility.</p> <p>16. On 02/27/15, the Administrator and the DON informed the Medical Director of the specific IJ citations, and discussed the facility's plan for correction of the deficient practice.</p> <p>17. On 02/27/15, the Administrator and the DON in-serviced the facility's two (2) SSD's, the MDS Nurses and the Medical Records Coordinator related to the facility's new policy and procedure regarding Advance Directives, which includes the following actions: Social Services will review each resident's Advance Directives upon admission to the facility, including their wishes regarding code status, obtain a Physician's Order for the code status, obtain consent from the resident and/or the Power of Attorney (POA), and initiate the Advance Directives Care Plan; the MDS Nurses will audit the Initial Care Plans for the presence of Advance Directives within 72 hours of admission; and the Interdisciplinary Care Plan Team will review all residents' Advance Directives during the regularly scheduled Care Plan meetings.</p>	F 309		
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F 309	Continued From page 119 18. On 02/27/15 through 03/02/15, all staff from every department, including Nursing, Dietary, Maintenance, Social Services, Activities, and Housekeeping, was in-serviced by the DON, SSD, SDC, QA Officer, and the Nursing Supervisor related to Advance Directives and Residents' Rights. Each staff member was required to complete a post-test with 100% accuracy on the subject matter. Immediate re-education was provided for any incorrect answers. 19. Between 02/27/15 and 03/02/15, all nursing staff, including nurses, KMAs and SRNA's were educated by the DON, SSD, SDC, QA Officer and the Nursing Supervisor on the following: differentiation between DNR and Full Code status; how to identify a resident's code status; how to call for and initiate a Code Blue; who should respond to a Code Blue immediately; where to locate the crash cart; contacting the Physician and calling 911; continuation of the code until EMS arrival; notification of the DON and Administrator; and documentation of all details of the code in the medical record. In addition, the training included how to manage the resident who had a DNR status, including an assessment for vital signs at five (5) minute intervals, pronouncement of death, notification of the Physician, the family and/or POA, and the DON and Administrator, and documentation in the medical record. All participants were required to complete a post-test related to the training with 100% accuracy, with immediate re-education provided for any incorrect answers. 20. Between 02/27/15 and 03/02/15, all nurses,	F 309			

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KMA and SRNA's were in-serviced regarding the requirement for inclusion of the resident's Advance Directives and code status on the Comprehensive Care Plan. The training was provided by the DON, SDC and Nursing Supervisor. All participants were required to complete a post-test related to the training with 100% accuracy, with immediate re-education provided for any incorrect answers. Two (2) staff members were on leave and did not receive the education. They will not be added to the schedule until they are in-serviced and able to complete the post-test accurately to ensure their competency.

21. As of 02/27/15, fifty-six (56) of one hundred and twenty-eight (128) residents had an Advance Directive for Full Code status.

22. On 02/28/15, the DON updated the new hire orientation outline to include training and post-tests related to professional nursing standards, identifying code status, Comprehensive Care Plans, Advance Directives, Residents' Rights, Code Blue Information sheet, Code Blue Nurses' Note guide, and the facility's Code Blue Protocol. In addition, orientation packets were developed for agency staff to educate on the same topics. All agency staff will be expected to complete the post-tests with 100% accuracy prior to providing direct care.

23. Between 02/28/15 and 03/02/15, all nurses, KMAs and SRNA's were in-serviced by the DON, SDC and the Nursing Supervisor related to professional nursing standards. Training references included the Lippincott Manual of Nursing Practice as it pertained to the provision of CPR, documentation, ensuring a Physician's

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F 309	<p>Continued From page 121</p> <p>Order for DNR status, and honoring each resident's Advance Directives. All participants were required to complete a post-test related to the training with 100% accuracy, with immediate re-education provided for any incorrect answers.</p> <p>24. On 03/03/15, the facility conducted a mock Code Blue drill to assess staff knowledge retention after training related to initiating a Code Blue event immediately, and evaluated response time, accuracy in determining the code status of the mock resident, and adherence to the facility's policy and procedure. A mock Code Blue drill will be conducted quarterly by the SDC, QA nurse or the DON, and will cover all shifts on weekdays and weekends. Results of the drills will be brought by the Administrator or the DON to the facility QA meetings for interdisciplinary review. Any staff members identified to not follow facility policy and procedures will be re-educated, and a competency test will be administered until the staff member is able to display a thorough and accurate understanding of the policy and procedure.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> 1. Review of the facility's investigation of the incident revealed SRNA #1, Nursing Supervisor #1 (LPN #1/Supervisor), RN #1 and RN #2 were interviewed related to the Code Blue event involving Resident #1. Continued review of the investigation revealed RN #1 and RN #2 were suspended on 02/18/15, pending the investigation results. <p>Interview, on 03/04/15 at 6:00 PM, with the DON revealed RN #1 called the facility on 02/21/15,</p>	F 309		

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F 309	<p>Continued From page 122 and stated she was quitting and would not be returning to work, and hung up.</p> <p>2. The State Survey Agency received the initial report regarding the delayed Code Blue event involving Resident #1 on 02/18/15.</p> <p>3. Review of the facility's investigation documentation of the incident revealed the DON notified Resident #1's family of RN #1's delay in initiating a Code Blue.</p> <p>Phone contact was attempted with Resident #1's RP/family which was unsuccessful and a message was left. However, no return call was received.</p> <p>4. Review of the facility's in-service sign-in form dated 02/18/15 and 02/19/15, revealed 100% of nursing staff did receive training on the facility's Code Blue Protocol, which included education on immediate initiation of CPR, based on Physician's Orders and the individual's Advance Directives and stated wishes regarding their code status, when a resident was discovered to be without vital signs.</p> <p>Interviews on 03/04/15: at 1:55 PM with LPN #1; at 4:15 PM, with LPN #2; at 3:20 PM, with LPN #8; and at 4:50 PM with RN #4 revealed they were inserviced on the facility's Code Blue procedures, how to identify a resident's code status, when to initiate CPR, and the code process.</p> <p>Interviews on 03/04/15: at 3:49 PM, with SRNA #13, at 4:35 PM with SRNA #9; and at 4:58 PM with SRNA #12 revealed they were inserviced on the facility's Code Blue process, how to identify a</p>	F 309			

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F 309	<p>Continued From page 123</p> <p>resident's code status, call a Code Blue, take crash cart to room and wait for further directions.</p> <p>5. Review of the facility's document titled, "Medical Emergency Code Reference", not dated, revealed the DON had revised the facility's policy and procedure to include the requirement for adding each resident's code status to the care plan.</p> <p>Interviews on 03/04/15 at 5:20 PM, with Social Services (SS) #13, and at 5:30 PM, with SS #2, revealed they were in-serviced related to SS responsibility for implementing an interim Advance Directive care plan to include the code status for all new residents upon admission and/or readmission.</p> <p>Interview on 03/06/15 at 4:50 PM, with the RN #4/MDS Coordinator revealed the MDS nurses were in-serviced related to MDS' responsibility to audit the interim care plan within 72 hours of every resident's admission, and/or readmission, and to assure Advance Directives with code status were present.</p> <p>6. Interview, on 03/06/15 at 8:30 PM, with the DON revealed she developed a new system for Quarterly Care Plan meetings to discuss with residents and their RP if a change in code status is desired by the resident.</p> <p>Review of the facility's policy titled, "Care Plans" with a revised date of 02/27/15, revealed the Care Plan Team would review with the resident any existing/current Advance Directives to determine if a change in code status was desired by the resident at the Quarterly Care Plan meetings.</p>	F 309		
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F 309 Continued From page 124

Interviews, on 03/06/15 at 4:00 PM, with SS #2 and at 4:30 PM with SS #13, revealed Advance Directives including the code status was discussed with each resident at every care plan meeting now.

Interview, on 03/06/15 at 4:50 PM, with RN #4/MDS Coordinator, revealed the care plan team did discuss Advance Directives including the code status with the resident or RP at each care plan meeting now.

7. Interview, on 03/06/15 at 6:30 PM, with the DON revealed she had developed a Code Blue information form which was to be attached to Incident Reports for all Code Blue events that were to be turned in to her. The DON revealed she had also developed a reference book for all Code Blue events which were placed with each crash cart. Per the DON, she will submit all investigations to the facility's monthly QA meeting.

Observation on 03/06/15 from 3:00 PM through 3:20 PM of each crash cart in the facility revealed a reference book for Code Blue events which included the Code Blue documentation form. Review of the facility's Code Blue reference book revealed a form titled, "Code Blue Documentation", dated 02/18/15, which was revised 02/27/15.

8. On 03/06/15 at 2:00 PM a call was placed to the Ombudsman with no answer, a message left to return a call. The Ombudsman returned the call and revealed the Administrator did notify her of the delay in initiating a Code Blue for Resident #1, and explained the corrective actions taken by the facility and invited her to participate.

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F 309	Continued From page 125 Interview with the Administrator on 03/06/15 at 6:15 PM, revealed he had called the Ombudsman on 02/19/15 as per the AOC. 9. Interview with the Administrator on 03/05/15 at 6:15 PM, confirmed the facility's Medical Director was contacted by phone for the QA meeting on 02/19/15, to notify him of the delay in providing CPR and to discuss a plan of action. Interview, on 03/06/15 at 3:00 PM, with the facility's Medical Director and Resident #1's attending Physician revealed the Administrator, the DON and the RDCS had called on 02/18/15, to discuss the events which occurred with Resident #1's code on 02/18/15. He stated "we" did put plans into action, and he felt the facility had a very active QA program. The Medical Director revealed the facility had a meeting monthly and he "rarely" missed a meeting. 10. Review of the facility's Ad hoc QA meeting sign-in sheet revealed the attendees included the Medical Director, Administrator, DON, QA Nurse, RDCS, RDO, UMs and SDC. Interview, on 03/08/15 at 3:50 PM, with Medical Records (MR) revealed during the QA meeting assignments were made and MR was assigned duties related to the Advance Directives regarding completing a daily audit. Per interview, the audit was for identification/verification of all residents' code status, by ensuring the code status on the residents' door name plate, SRNA care plan, Comprehensive Care Plan, spine of the residents' charts, and inside the front cover of the charts matched the Physician Order. Further interview revealed this was reviewed by the	F 309			

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F 309	Continued From page 126 DON/Administrator daily. Interview, on 03/06/15 at 5:25 PM, with the QA Nurse revealed on 02/19/15, a QA meeting was held with the Medical Director, Administrator, DON, Nursing Supervisor, SS, Dietary, Activities Director, Director of Rehabilitation and QA in attendance. Per interview, the QA attendees reviewed and authorized revision of the facility's current code status policy to include each resident's code status on the care plan. The QA Nurse revealed members were assigned specific tasks on the check list which they developed to ensure ongoing compliance. Further interview revealed the QA attendees determined the root cause of CPR provision for Resident #1 was due to RN #1's failure to follow the facility's policies and procedures related to code status and discussed an action plan. Interviews, on 03/06/15 at 4:00 PM, with SS #2, and at 4:30 PM with SS #13, revealed SS was assigned duties related to the new policy and procedure for Advance Directives. Per interview, SS was to obtain consents from the resident or POA, notify the nursing supervisor of the unit the resident was admitted to, and obtain a Physician's Order for the code status decision. Further interview revealed SS will initiate the Advance Directive care plan for residents. Interview on 03/06/15 at 4:50 PM, with RN #4/MDS Coordinator revealed the MDS nurses were assigned duties related to the new policy and procedure for Advance Directives. Per interview, MDS' duties were to audit the interim care plan within 72 hours of every admission, and/or readmission, to assure Advance Directives with code status were present.	F 309		

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F 309	<p>Continued From page 127</p> <p>11. Interview, on 03/06/15 at 3:50 PM, with Medical Records (MR) revealed MR was assigned duties related to Advance Directives to complete a daily audit for identification/verification of all residents' code status by ensuring the code status on the residents' door name plate, SRNA care plan, comprehensive care plan, spine of the chart, and inside the front cover of the chart matched the Physician's Order. Per interview, the audits were turned into the DON/Administrator daily, with the first audit completed on 02/19/15, when MR and the QA Nurse audited 100% of residents' charts for verification of their code status.</p> <p>Interview, on 03/06/15 at 5:25 PM, with the QA Nurse revealed MR and herself completed the daily audit Monday through Friday for identification and verification of all residents' code status by ensuring the code status on the residents' door name plate, SRNA care plan, Comprehensive Care Plan, spine of the chart, and inside the front cover of the chart matched the Physician's Order and the House Supervisor completed the audits on the weekend. Per interview, the audits would continue until the Immediate Jeopardy (IJ) was abated.</p> <p>Review of the audits performed by MR and the QA Nurse confirmed completion of the tasks as assigned per the AOC.</p> <p>Interview on 03/06/15 at 6:30 PM, with the DON revealed the code status audits were turned in daily for her review.</p> <p>12. Review of the Central Supply Clerk's (CSC) audit forms (Crash Cart Check List form)</p>	F 309		
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F 309	<p>Continued From page 128</p> <p>revealed the six (6) crash carts was audited daily for expired items and the presence of adequate supplies, with no issues identified beginning 02/19/15.</p> <p>Interview, on 02/24/15 at 8:55 AM, with the CSC revealed he checked the six (6) crash carts daily Monday through Friday, and the House Supervisor checked them on the weekends for expired items and to ensure they were locked. Per interview, while doing the audit if an item was used from a crash cart the item was replaced and a new breakaway lock would be applied to the cart. The CSC revealed audits continued to be performed.</p> <p>Interview on 03/06/15 at 6:30 PM, with the DON revealed the audit results were reviewed and would be taken to the facility's monthly QA meeting.</p> <p>13. Review of seven (7) employee files on 03/06/15, revealed the employee files were complete with current CPR cards, active nursing licenses and SRNA certifications, and background checks.</p> <p>Interview on 03/06/15 at 6:30 PM, with the DON revealed the employee file audits were completed as per the AOC on 03/03/15.</p> <p>14. Review of the audit completed on 02/19/15, revealed fifty (50) residents who had expired in the facility between 12/04/12 and 02/21/15, medical records were audited. Of the fifty (50) deaths, twenty-one (21) were identified to have occurred during the time frame.</p> <p>Interview with MR on 03/06/15 at 3:50 PM,</p>	F 309		

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revealed the audits were completed of residents who had expired from 12/04/12 to 02/21/15, the timeframe during which RN #1 was employed. Per interview, twenty-one (21) of the fifty (50) deaths occurred when RN #1 was on duty; however, only Resident #1 had been a Full Code, with the rest having a DNR status.

15. Interview, on 03/06/15 at 5:55 PM, with the DON revealed RN #1 had called the facility on 02/21/15, and said she quit and would not be returning to work.

16. Interview, on 03/06/15 at 3:00 PM, with the facility's Medical Director revealed the Administrator and DON had informed him of the IJ deficiencies and they discussed the facility's plan for correction for the identified deficiencies.

17. Review of the facility's Inservice education revealed the two (2) SSD's, MDS Nurses and MR Coordinator were inserviced on 02/27/15, as per the AOC.

Interview, on 03/06/15 at 3:50 PM, with MR Coordinator revealed she had received education related to the new policy and procedure for Advance Directives. Per interview, her assigned duties related to the Advance Directives were to complete a daily audit for identification/verification of all residents' code status by ensuring the code status on the residents' door name plate, SRNA care plan, Comprehensive Care Plan, spine of the chart, and inside the front cover of the chart matched the Physician's Order. The MR Coordinator revealed the audits were reviewed by the DON/Administrator daily.

Interviews, on 03/06/15 at 4:00 PM, with SS #2