

*Facility  
185144*

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

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
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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 000 INITIAL COMMENTS

AMENDED

An Abbreviated/Partial Extended Survey investigating KY00022851 was initiated on 02/23/15 and concluded on 03/06/15. KY00022851 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 02/26/15 and determined to exist on 02/18/15 with deficiencies cited at 42 CFR 483.10 Resident Rights, F-155; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25 Quality of Care, F-309; and 42 CFR 483.75 Administration, F-514 all at a Scope and Severity of a "J"; and 42 CFR 483.20 Resident Assessment, F-279 at a Scope and Severity of a "K". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care, F-309. The facility was notified of the Immediate Jeopardy on 02/26/15.

Resident #1, who implemented Advance Directives on 09/11/12, requesting to be a Full Code, was found non-responsive on 02/18/15 at approximately 8:30 AM by State Registered Nursing Assistant (SRNA) #1. SRNA #1 immediately notified Registered Nurse (RN) #1 who went to Resident #1's room where she found the resident unresponsive, checked for a pulse with none found, and observed no respirations. However, RN #1 did not immediately initiate Cardiopulmonary Resuscitation (CPR) and failed to implement the facility's policy and procedures for calling a "Code Blue". 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

F 000

*Revisit  
3/23/15 - 3/24/15  
Recommend to  
put back in compliance  
P. Jostman*

APR 10 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X8) DATE 4-10-15
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>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.</p> <p>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, thirty-five (35) to forty (40) minutes after the resident was found non-responsive. Emergency Medical Services (EMS) were called per 911, arrived and transported Resident #1 to the hospital Emergency Room (ER). Resident #1 was pronounced deceased at 9:38 AM in the ER. Interview revealed the facility did not have a system in place to provide routine training and/or Mock Code drills for staff to ensure proficiency in the event of a Code prior to this incident.</p> <p>An acceptable credible Allegation of Compliance was received on 03/04/15, alleging removal of the Immediate Jeopardy on 03/04/15. The State Survey Agency verified the Immediate Jeopardy was removed as alleged on 03/04/15, prior to exit on 03/06/15, with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-155; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25 Quality of Care, F-309; and 42 CFR</p>	F 000			

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F 000	Continued From page 2 483.75 Administration, F-514 all at a Scope and Severity of a "D"; and 42 CFR 483.20 Resident Assessment, F-279 at a Scope and Severity of an "E".	F 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
F 155 SS=J	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and procedures it was determined the facility failed to have an effective system to ensure Advance Directives for one (1) of eight (8) sampled residents (Resident #1) were honored regarding his/her requested Full Code status.</p>	F 155	<p>F 155 D: Right to Refuse; Formulate Advance Directives</p> <p><i>Residents Affected</i> Resident #1, who implemented advance directive on 9-11-12, requesting to be a full code was found non-responsive on 2-18-15 by a SRNA. The SRNA notified the RN nurse caring for Resident #1. The RN assessed and found no vital signs but delayed the initiation of CPR. The SRNA went to get another nurse who checked his vital signs who then went to check his code status and get the unit supervisor. The unit supervisor instructed the two nurses to start CPR and she went to call 911. EMS arrived and continued the CPR until arrival at</p>	

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F 155	Continued From page 3  On 09/11/12, Resident #1 signed Advance Directives requesting to be a Full Code (Full Code indicates life-saving measures would be instituted in the event of cardiac or respiratory failure) with life-saving measures to include Cardpulmonary Resuscitation (CPR). However, on 02/18/15 at approximately 8:30 AM, when State Registered Nursing Assistant (SRNA) #1 entered Resident #1's room, found him/her unresponsive and notified Registered Nurse (RN) #1, the RN failed to honor the resident's Advance Directives regarding his/her Full Code status. RN #1 checked for Resident #1's pulse, could not obtain one and failed to initiate CPR as per the resident's Advance Directives. SRNA #1 went to another unit and told RN #2 the resident was unresponsive and requested the RN come to Resident #1's room. Upon arrival to Resident #1's room, RN #2 asked RN #1 what the resident's code status was, as she had not checked. RN #1 informed her Resident #1 was a Full Code, however, neither RN initiated CPR as per the resident's Advance Directives. 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.  The facility's failure to ensure residents' Advance Directives regarding their requested Full Code status was followed has caused or is likely to cause serious injury, harm, impairment, or death	F 155	the hospital where Resident #1 was pronounced deceased.  <i>Identification/Protection of Other Residents</i> On 2-19-15, The Medical Records Coordinator audited 100% of the 128 residents' code status including: MD orders, care plan, SRNA care plan and DNR identification. The Medical Records Coordinator added each residents DNR and Full Code status to each resident's care plan.  On 2-19-15, the Medical Records Coordinator and the Regional Director of Clinical Services audited all of the 50 residents who had expired at the facility during RN #1's employment; which was from 12-4-2012 thru 2-21-15, to determine if she had been involved in any other Code Blue emergencies. There were no findings that RN #1 had been involved in any other Code Blue while at Homestead, except for Resident #1. In fact, of the 50 deaths determined to have occurred during RN #1's employment, RN #1 had worked for 21 of them, and of the 21 all were DNR except for the event with Resident #1 on 2-18-2015.  An audit was initiated and completed on 2-19-15 by the QA Nurse and the Medical Records Coordinator comparing each residents advance directive decisions, physician's orders including code status, comprehensive		

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F 155	<p>Continued From page 4</p> <p>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 03/06/15, 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 policy titled, "Advance Directives", revised November 2010, revealed the Policy noted Advance Directives included preferences regarding treatment options which included Do Not Resuscitate (DNR). However, continued review revealed no documented evidence the Policy addressed residents requesting to be a Full Code status. Per the Policy, the Director of Nursing (DON) or designee would notify the Physician of residents' Advance Directives so appropriate orders could be documented in the resident's medical record and care plan.</p> <p>Record review revealed the facility admitted the resident on 06/22/12, and re-admitted him/her on 09/05/14, with diagnoses which included Chronic Airway Obstruction, Acute Respiratory Failure, Chronic Ischemic Heart Disease and Chronic Bronchitis. Review of Resident #1's Quarterly</p>	F 155	<p>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 a total of 128 residents. 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 will be conducted on the weekends by the weekend house supervisor 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>The QAA committee consists of the following members of the interdisciplinary team: Administrator, Director of Nursing, Medical Director, Director of Therapy, Social Services Director, Dietary Manager, Activities Coordinator, Consultant Dietician, Quality Assurance Nurse, and Nursing Supervisor. If any discrepancies are found, corrections will be made immediately. The audits are being</p>	<i>Done</i>

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F 155	<p>Continued From page 5</p> <p>Minimum Data Set (MDS) Assessment dated 12/07/14, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated no cognitive impairment. Review of the monthly Physician's Order dated February 2015, revealed Resident #1 had an order to be a Full Code. Continued record review revealed a "Consent to Withhold Life Prolonging Extraordinary Measures" form dated 09/11/12, which gave residents the option to check whether they wanted CPR or not. Continued review of the 09/11/12 Form, signed by Resident #1 revealed the resident had checked he/she wanted to receive CPR. Review of the "Condition Alert" document in Resident #1's medical record revealed he/she was a Full Code.</p> <p>Review of the Nurse's Notes revealed a Note documented by RN #1 on 02/18/15 timed 8:40 AM, which stated SRNA #1 had informed RN #1 of Resident #1 not looking "too good". The Note revealed RN #1 went with SRNA #1 to Resident #1's room, where she shook the resident without a response, and checked for a pulse with none obtained and the resident had no respirations. Continued review revealed no documented evidence RN #1 immediately initiated CPR as per Resident #1's Advance Directives. Per the Note, RN #1 requested assistance from a nurse on another unit, and when she arrived CPR was then initiated and 911 called. Further review revealed Emergency Medical Services (EMS) arrived at 9:10 AM, placed Resident #1 on a backboard, and initiated an Automated External Defibrillator (a portable device which checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm used treat sudden cardiac arrest) with no pulse obtained and CPR</p>	F 155	<p>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.</p> <p>Beginning 2-27-15 and finishing on 3-2-15, all nursing staff which included RN's, LPN's, KMA's and SRNA's were re-educated by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and Nursing Supervisor on the difference between a DNR and full-code, how to identify a residents code status, procedure on 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, to notify the DON and Administrator, and to document all details of the code in the medical record. The in-servicing also included: In the event that a resident is found unresponsive the facility requires the following; Code blue may be initiated by an RN or LPN. Overhead page three (3) times CODE BLUE and room number or location (do not page resident's name). All available nursing staff must respond right away. Crash cart from the closest nursing station will be taken to location by any staff member at the nurse's station. Check code status (any staff member). An RN or LPN will assess resident for vital signs including: Respiration-rate and</p>		

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F 155	<p>Continued From page 6 was continued.</p> <p>Review of the EMS Run Sheet dated 02/18/15, revealed EMS were notified at 9:06:54 AM and arrived at the facility at 9:12:51. Review revealed at 9:13:14 EMS personnel were with Resident #1. Continued review revealed the chief complaint was documented as "cardiac arrest/death", CPR was continued and Resident #1 was intubated. Further review revealed Resident #1 was transported to the hospital ER at 9:29:37 AM.</p> <p>Review of the hospital ER record revealed EMS transported Resident #1 to the ER, where the resident was triaged at 9:33 AM. Continued review revealed Resident #1 presented to the ER in "cardio-pulmonary arrest", remained in asystole (no heart rate) in spite of interventions and was pronounced expired at 9:38 AM.</p> <p>Review of the facility's investigation dated 02/18/15, revealed the facility investigated an allegation of neglect regarding Resident #1, where RN #1 had not honored the resident's Advance Directives to be a Full Code and had not initiated CPR as per the resident's request. Per the investigation, RN #1 had not performed CPR due to her emotional state over finding Resident #1 expired. Continued review revealed the facility determined the other staff involved had followed the facility's policy and procedure related to "code status". Further review revealed the other staff included, SRNA #1, LPN #1/Supervisor and RN #2. However, interview with staff revealed the facility's policy was not followed regarding checking the resident's code status and initiating CPR if indicated.</p> <p>Interview was attempted and was unsuccessful with RN #1 on 02/24/15 at 1:05 PM, 2:00 PM,</p>	F 155	<p>quality, Circulation, pulse, and blood pressure, Glucose level, if indicated, Blocked airway, choking and to immediately initiate CPR, if appropriate until EMS arrival. Contact medical doctor and/or send out 911. If a DNR and an RN determines that CPR should not be initiated, a Registered Nurse may pronounce death after obtaining vital signs X three (3) at five (5) minute intervals. Document the vital signs in the medical record, notify physician, family, and/or responsible party. Notify DON and Administrator. Lastly, document all details of the code in the medical record.</p> <p>Upon completion of the re-education, a post test was administered on Identification of the Code Status; Care Planning; Advance Directives; Resident Rights; Code Blue Documentation; and Code Blue Protocol to the nursing staff by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and the Nursing Supervisors. For anyone found to have answered a question incorrectly, they were promptly re-inserviced on the subject matter and asked to re-answer the question until they answered correctly. These records are being maintained in the facility In-Service Post Test folder.</p> <p>On 2-27-15 thru 3-2-15, re-inservicing was initiated for all staff from each</p>	
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F 155	Continued From page 7 4:30 PM and 5:15 PM, and on 02/25/15 at 10:10 AM.  Interview, on 02/24/15 at 10:45 AM, with SRNA #1 revealed on 02/18/15 at approximately 8:30 AM, she had found Resident #1 unresponsive, and immediately notified RN #1 of this information. SRNA #1 stated RN #1 assessed Resident #1, observed no breathing and then began to cry. Per interview, SRNA #1 had to go to another unit and get RN #2 to come to Resident #1's room. However, per SRNA #1, CPR was not initiated at that time, and was not started until LPN #1/Supervisor arrived and told them CPR had to be initiated. Per SRNA #1, this was approximately ten (10) minutes after she had found Resident #1 unresponsive.  Interview with RN #2, on 02/24/15 at 12:25 AM and 02/25/15 at 11:30 AM, revealed SRNA #1 informed her at approximately 8:35 AM on 02/18/15, that she needed to go to Resident #1's room. RN #2 stated she asked RN #1, who was present in the room, what Resident #1's code status was and was informed he/she was a Full Code, but RN #1 stated she was not going to put the resident "through that". According to RN #2, when she found out Resident #1 was a Full Code, she should have started CPR. However, she did not because she felt she didn't have help because RN #1 refused to perform CPR on the resident. Per interview, CPR was not initiated until after she notified LPN #1/Supervisor who came and told them they had to do CPR.  Interview with LPN #1/Supervisor, on 02/24/15 at 12:05 PM, revealed she arrived in Resident #1's room at approximately 8:00 AM after RN #2 paged her overhead. LPN #1/Supervisor	F 155	Department; including, Nursing, Dietary, Maintenance, Social Services, Activities, and Housekeeping regarding Advance Directives and Resident Rights and all in-services were completed on 3-2-15. The in-servicing was conducted by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and Nursing Supervisor. After the in-service each employee was given a post test on advance directives and resident rights. For anyone found to have answered a question incorrectly, they were promptly re-in serviced on the subject matter and asked to answer the question until they answered correctly.  In-services were provided to all nursing staff on 2-27-15 which included RN's, LPN's, KMA's and SRNA's, regarding comprehensive care plans which should include each resident's advance directive decisions. This in-service was conducted by the DON, Staff Development Coordinator, and Nursing Supervisor and was completed on 3-2-15. Of the two (2) employees on leave, which we were unable to get in contact with, will not be added to the schedule until in-services are completed and a post test is conducted to determine competency. The in-servicing included the facility policy and procedure related to comprehensive care plans, with special focus on the revision to include code	<i>Done</i>	

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F 155	<p>Continued From page 8</p> <p>revealed she was aware Resident #1 was a Full Code. However, according to LPN #1/Supervisor, RN #1 and RN #2 were not performing CPR. She told them they had to start CPR and 911 should be notified. LPN #1/Supervisor revealed CPR should have been initiated, immediately after RN #1 assessed Resident #1 to have no pulse and not to be breathing. Per interview, the "code" was not performed timely, but should have been.</p> <p>Interview with LPN #2/MDS Nurse on 02/24/15 at 2:40 PM and RN #4/MDS Coordinator at 3:00 PM, revealed LPN #1/Supervisor called, at approximately 9:00 AM to 9:05 AM, to verify if a resident was a Full Code and was found unresponsive, should CPR be initiated anyway. Per interview, LPN #2/MDS Coordinator told LPN #1/Supervisor "yes, CPR had to be initiated". Interview revealed both LPN #2/MDS Nurse and RN #4/MDS Coordinator went immediately to Resident #1's room and CPR had not been initiated. According to LPN #2/MDS Nurse, RN #1 was "emotional" and told her she did not want to do CPR on Resident #1. Per LPN #2/MDS Nurse, RN #1 and RN #2 told her Resident #1 was found non-responsive at approximately 8:45 AM; however, CPR was not initiated until about 9:10 AM.</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 Resident #1 was a Full Code, CPR should have been started immediately; however, this was not done. The DON stated RN #1 told her she "just didn't want to do that" (CPR) to Resident #1 and RN #1 showed "no remorse".</p>	F 155	<p>status and advance directives in the comprehensive care plan.</p> <p>Upon completion of the re-education, a post test was administered to all nursing staff by the DON. For anyone found to have answered a question incorrectly, they were promptly re-instructed on the subject matter and asked to re-answer the question until they answered correctly. These records are maintained in the facility In-Service Post Test folder.</p> <p><i>Systemic Changes</i> On 2-19-15, a new system was developed by the DON related to quarterly care plan meetings with the resident, or appropriate responsible party, Social Worker, Nurse, and MDS to determine if any changes in advanced directives/code status are desired by the resident and/or POA. Any changes will be noted by the Social Worker in the comprehensive care plan, and audited by the Medical Records Coordinator daily and its accuracy authenticated on the Medical Records Advance Directive/Code Status Audit Form. The daily audit 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</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165144	(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 1605 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 155	Continued From page 9 Interview, on 2/26/15 at 3:45 PM, with the Administrator revealed if a resident was a Full Code, CPR should be immediately initiated. Per interview, RN #1 told him and the DON she "couldn't do that" (CPR) to Resident #1. According to the Administrator, RN #1 did not follow Resident #1's advance directive, and did not act appropriately and when he and the DON asked her why she couldn't initiate the "Code Blue", she stated she knew she was supposed to, but believed Resident #1 "would not have wanted that". He stated RN #1 told him and the DON she knew she should have initiated the "Code Blue" as per facility policy; however, she couldn't. 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:  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	F 155	the DON. After six (6) months, the QAA committee will determine frequency of continual auditing to maintain future compliance.  On 2-19-15, the Medical Records Coordinator added each residents' DNR and Full Code status to each resident's comprehensive care plan. This was done for a total of 128 residents. The advanced directives for code status were previously identified on the physician's orders, on the spine of the medical record and if a DNR, there was a red dot on the door of the resident's room.  On 2-19-15, the Director of Nursing revised the facility's code status policy and procedure to include adding the code status in the comprehensive plan of care. In-servicing regarding the facility's revised code status policy was initiated on 2-19-15 and completed on 3-1-15 for all nursing staff; including, RNs, LPNs, and SRNAs.  On 2-19-15, Initiation of investigating all code blue events: 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. Results of the investigation will be submitted to the QAA monthly meeting by the DON. The QAA meeting consists of the		

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F 155	<p>Continued From page 10</p> <p>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.</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>	F 155	<p>following members of the interdisciplinary team: Administrator, DON, Medical Director, Quality Assurance Nurse, Dietary Manager, Social Services Director, Consultant Dietician, Activities Coordinator, Nursing Supervisor, and Director of Rehab. 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>The Staff Development Coordinator or QA Nurse will conduct Quarterly Code Blue Drills for licensed staff on all three (3) shifts both weekends and weekdays beginning 3-3-15. The Code Blue drills are being reviewed by the DON; in addition the DON is submitting the drills to the monthly QAA meetings for monitoring and evaluation.</p> <p>The Medical Records Coordinator and the QA nurse is conducting daily code status audits comparing Advanced Directives, MD orders, care plans, SRNA care plans, chart spine and door for DNR identification for every resident in the building. The total number of residents may change based on daily census changes; however, this daily audit is being done for 100% of the facility's residents. The daily auditing will continue until substantial</p>	<p><i>Done</i></p>

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F 155	<p>Continued From page 11</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 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</p>	F 155	<p>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 for all nursing staff, including RNs, LPNs, and SRNAs and completed on 3-1-15.</p> <p>On 2-27-15, the Administrator and DON in-serviced the two Social Services Directors, the RN and the LPN MDS nurses, and the Medical Records Coordinator on the new policy and procedure for advance directives. Upon admission the resident's advance directive including code status is being obtained by the Admission coordinator and/or social services, who will obtain the consents from the POA and/or residents and is notifying the nursing supervisor of that unit to obtain a physician's order for the code status decision. The social services directors will initiate the advance directive care plan. The MDS nurses is checking the initial admission care plans for advance directives within 72 hours of</p>	
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F 155 Continued From page 12 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 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.

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

F 155 the admission. The interdisciplinary care plan team is reviewing the residents advance directives during the regularly scheduled MDS/care plan meetings in accordance to OBRA and OMRA requirements.

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 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.

*Monitoring*  
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

*Jane*

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F 155	<p>Continued From page 13</p> <p>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> <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>	F 155	<p>the policy. This audit consisted of a total of 128 residents; 100% of residents in the facility.</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 are 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>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 procedure. The in-service will cover</p>	
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F 155	Continued From page 14  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.  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	F 155	the difference between a DNR and full code, how to identify a residents code status, procedure on how to call for and initiate a Code Blue, CPR, who should respond to a Code Blue immediately, where to locate the crash cart, contacting the medical doctor and dialing 911, to notify the Administrator and DON, and to document all details of the code in the medical record. Additionally, professional nursing standards as outlined in the Lippincott Manual of Nursing Practice and facility 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. The test will evaluate response time, accuracy in determining code-status of the <i>mock resident</i> , as well as adherence to the facility code-status policy and procedure. Results of this drill is being documented by the Staff Development Coordinator, QA nurse or DON and submitted to the DON and Administrator for review. Any staff members identified to not follow facility policy and procedure will be re-in-serviced on a one-on-one	

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F 155	<p>Continued From page 15</p> <p>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.</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</p>	F 155	<p>basis 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. Additionally, the results of these drills are being submitted by the Administrator or DON to the facility QAA meeting for interdisciplinary review.</p> <p>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 been no code blue events since Resident #1 in the facility to date other than the mock code blue drills.</p> <p>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</p>	<i>Done</i>	

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F 155	Continued From page 16 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 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.  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	F 155	Medical Director was informed of and approved all steps taken to ensure both immediate and ongoing compliance.  <i>Date of Correction:</i> March 24, 2015	3-24-15	
		F 279	F 279 D: Develop Comprehensive Care Plans  <i>Residents Affected</i> Resident #1, who implemented advance directive on 9-11-12, requesting to be a full code was found non-responsive on 2-18-15 by a SRNA. The SRNA notified the RN nurse caring for Resident #1. The RN assessed and found no vital signs but delayed the initiation of CPR. The SRNA went to get another nurse who checked his vital signs who then went to check his code status and get the unit supervisor. The unit supervisor instructed the two nurses to start CPR and she went to call 911. EMS arrived and continued the CPR until arrival at the hospital where Resident #1 was pronounced deceased.  Resident #2 code status has been identified as DNR. An advanced directive care plan has been developed by the MDS coordinators and code status is being audited daily by the Medical records coordinator and the	Done	

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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 VERSAILLES ROAD LEXINGTON, KY 40504	
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F 155	<p>Continued From page 17</p> <p>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"> <li>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.</li> <li>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.</li> <li>2. The State Survey Agency received the initial report regarding the delayed Code Blue event involving Resident #1 on 02/18/15.</li> <li>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.</li> </ol> <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> <ol style="list-style-type: none"> <li>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</li> </ol>		<p>QA nurse on the weekdays Monday thru Friday and by the house supervisor on the weekends.</p> <p>Resident #3 code status has been identified as DNR. An advanced directive care plan has been developed by the MDS coordinators and code status is being audited daily by the Medical records coordinator and the QA nurse on the weekdays Monday thru Friday and by the house supervisor on the weekends.</p> <p>Resident #4 code status has been identified as Full-Code. An advanced directive care plan has been developed by the MDS coordinators and code status is being audited daily by the Medical records coordinator and the QA nurse on the weekdays Monday thru Friday and by the house supervisor on the weekends.</p> <p>Resident #6 code status has been identified as DNR. An advanced directive care plan has been developed by the MDS coordinators and code status is being audited daily by the Medical records coordinator and the QA nurse on the weekdays Monday thru Friday and by the house supervisor on the weekends.</p> <p>Resident #7 code status has been identified as DNR. An advanced directive care plan has been developed by the MDS coordinators and code</p>

*Done*

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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.

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.

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.

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.

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.

Interview on 03/06/15 at 4:50 PM, with the RN #4/MDS Coordinator revealed the MDS nurses

status is being audited daily by the Medical records coordinator and the QA nurse on the weekdays Monday thru Friday and by the house supervisor on the weekends.

*Identification/Protection of Other Residents*

On 2-19-15, The Medical Records Coordinator audited 100% of the 128 residents' code status including: MD orders, care plan, SRNA care plan and DNR identification. The Medical Records Coordinator added each residents DNR and Full Code status to each resident's care plan.

Additionally, beginning on 3-10-15 and completed on 3-23-15, an audit was done by the MDS nurse comparing the MDS, CAAS/CATS to the comprehensive care plan to the SRNA care plan to ensure appropriate care issues had been care planned including advanced directives and code status decisions. The audit consisted of 100% of the facility's residents (128/128 residents).

On 2-19-15, the Medical Records Coordinator and the Regional Director of Clinical Services audited all of the 50 residents who had expired at the facility during RN #1's employment; which was from 12-4-2012 thru 2-21-15, to determine if she had been involved in any other Code Blue emergencies. There were no findings

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F 155	<p>Continued From page 19</p> <p>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 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</p>		<p>that RN #1 had been involved in any other Code Blue while at Homestead, except for Resident #1. In fact, of the 50 deaths determined to have occurred during RN #1's employment, RN #1 had worked for 21 of them, and of the 21 all were DNR except for the event with Resident #1 on 2-18-2015.</p> <p>Beginning 2-27-15 and finishing on 3-2-15, all nursing staff which included RN's, LPN's, KMA's and SRNA's were re-educated by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and Nursing Supervisor on the difference between a DNR and full-code, how to identify a residents code status, procedure on 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, to notify the DON and Administrator, and to document all details of the code in the medical record. The in-servicing also included: In the event that a resident is found unresponsive the facility requires the following; Code blue may be initiated by an RN or LPN. Overhead page three (3) times CODE BLUE and room number or location (do not page resident's name). All available nursing staff must respond right away. Crash cart from the closet nursing station will be taken to location by any staff member at the nurse's station. Check</p>	<i>Done</i>	

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F 155	<p>Continued From page 20</p> <p>Investigations to the facility's monthly QA meeting.</p> <p>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.</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 8:15 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</p>		<p>code status (any staff member). An RN or LPN will assess resident for vital signs including: Respiration-rate and quality, Circulation, pulse, and blood pressure, Glucose level, if indicated, Blocked airway, choking and to immediately initiate CPR, if appropriate until EMS arrival. Contact medical doctor and/or send out 911. If a DNR and an RN determines that CPR should not be initiated, a Registered Nurse may pronounce death after obtaining vital signs X three (3) at five (5) minute intervals. Document the vital signs in the medical record, notify physician, family, and/or responsible party. Notify DON and Administrator. Lastly, document all details of the code in the medical record.</p> <p>Upon completion of the re-education, a post test was administered on Identification of the Code Status; Care Planning; Advance Directives; Resident Rights; Code Blue Documentation; and Code Blue Protocol to the nursing staff by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and the Nursing Supervisors. For anyone found to have answered a question incorrectly, they were promptly re-inserviced on the subject matter and asked to re-answer the question until they answered correctly. These records are being maintained in the facility In-Service Post Test folder.</p>	<i>done</i>
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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, UMa and SDC.

Interview, on 03/05/15 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.

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.

*Systemic Changes*  
On 2-19-15, a new system was developed by the DON related to quarterly care plan meetings with the resident, or appropriate responsible party, Social Worker, Nurse, and MDS to determine if any changes in advanced directives/code status are desired by the resident and/or POA. Any changes will be noted by the Social Worker in the comprehensive care plan, and audited by the Medical Records Coordinator daily and its accuracy authenticated on the Medical Records Advance Directive/Code Status Audit Form. The daily audit 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.

On 2-19-15, the Medical Records Coordinator added each residents' DNR and Full Code status to each resident's comprehensive care plan. This was done for 100% of the facility's residents (128/128 residents).

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F 155	<p>Continued From page 22</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, 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</p>		<p>The advanced directives for code status were previously identified on the physician's orders, on the spine of the medical record and if a DNR, there was a red dot on the door of the resident's room.</p> <p>An audit was initiated and completed on 2-19-15 by 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.</p> <p>There were no corrections needed from these audits but the facility is continuing to conduct this audit daily Monday thru Friday by the QA nurse and the Medical Records Coordinator and will be conducted on the weekends by the weekend house supervisor 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>

*Don*

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F 155	<p>Continued From page 23</p> <p>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) 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>If any discrepancies are found, corrections will be made immediately. The audits are 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.</p> <p>On 2-19-15, the Director of Nursing revised the facility's code status policy</p> <p>code status in the comprehensive plan of care. In-servicing regarding the facility's revised code status policy was initiated on 2-19-15 and completed on 3-1-15 for all nursing staff; including, RNs, LPNs, and SRNAs.</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 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>done</i></p> <p><i>done</i></p>

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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.

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.

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.

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.

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

Additionally beginning on 3-10-15 and completed on 3-23-15, an audit was done by the MDS nurse comparing the MDS, CAAS/CATS to the comprehensive care plan to the SRNA care plan to ensure appropriate care issues had been care planned including advanced directives and code status decisions. This audit consisted of 100% of the facility's residents (128/128 residents).

**Monitoring**

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. 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

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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1806 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 155	<p>Continued From page 25</p> <p>revealed the two (2) SSD's, MDS Nurses and MR Coordinator were inserviced on 02/27/15, as per the AOC.</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</p>	F 281	<p>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>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.</p> <p><i>Date of Correction:</i> March 24, 2015</p> <p>F 281 D: Services Meet Professional Standards</p> <p><i>Residents Affected</i></p> <p>3-24-15</p>

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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 VERSAILLES ROAD LEXINGTON, KY 40504		
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F 155	<p>Continued From page 26</p> <p>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 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 5:06 PM with Dietary Aide #8; 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</p>		<p>Resident #1, who implemented advance directive on 9-11-12, requesting to be a full code was found non-responsive on 2-18-15 by a SRNA. The SRNA notified the RN nurse caring for Resident #1. The RN assessed and found no vital signs but delayed the initiation of CPR. The SRNA went to get another nurse who checked his vital signs who then went to check his code status and get the unit supervisor. The unit supervisor instructed the two nurses to start CPR and she went to call 911. EMS arrived and continued the CPR until arrival at the hospital where Resident #1 was pronounced deceased.</p> <p><i>Identification/Protection of Other Residents</i></p> <p>On 2-18-15 and 2-19-15 licensed nurses including RN's, LPN's, KMA's and SRNA's were re-inserviced by the RN Staff Development Coordinator on immediately initiating CPR when a Code Blue is called, or when a resident is discovered without vital signs and has an advanced directive to start CPR immediately, and honoring each Resident Rights. The facilities Code Blue protocol was used for the in-service.</p> <p>Then beginning 2-27-15 and finishing on 3-2-15, all nursing staff which included RN's, LPN's, KMA's and SRNA's were re-educated by the DON, Social Services Director, Staff</p>	<p><i>done</i></p> <p><i>done</i></p>

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F 155	<p>Continued From page 27</p> <p>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 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</p>		<p>Development Coordinator, Quality Assurance Officer, and Nursing Supervisor on the difference between a DNR and full-code, how to identify a residents code status, procedure on 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, to notify the DON and Administrator, and to document all details of the code in the medical record. The in-servicing also included: In the event that a resident is found unresponsive the facility requires the following: Code blue may be initiated by an RN or LPN. Overhead page three (3) times CODE BLUE and room number or location (do not page resident's name). All available nursing staff must respond right away. Crash cart from the closest nursing station will be taken to location by any staff member at the nurse's station. Check code status (any staff member). An RN or LPN will assess resident for vital signs including: Respiration-rate and quality, Circulation, pulse, and blood pressure, Glucose level, if indicated, Blocked airway, choking and to immediately initiate CPR, if appropriate until EMS arrival. Contact medical doctor and/or send out 911. If a DNR and an RN determines that CPR should not be initiated, a Registered Nurse may pronounce death after obtaining vital signs X three (3) at five (5) minute intervals. Document the</p>	

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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 155	<p>Continued From page 28</p> <p>#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 #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%.</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 required a post-test with 100% accuracy, with immediate re-education provided for any incorrect</p>		<p>vital signs in the medical record, notify physician, family, and/or responsible party. Notify DON and Administrator. Lastly, document all details of the code in the medical record.</p> <p>Upon completion of the re-education, a post test was administered on Identification of the Code Status; Care Planning; Advance Directives; Resident Rights; Code Blue Documentation; and Code Blue Protocol to the nursing staff by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and the Nursing Supervisors.</p> <p>For anyone found to have answered a question incorrectly, they were promptly re-instructed on the subject matter and asked to re-answer the question until they answered correctly. These records are being maintained in the facility In-Service Post Test folder</p> <p>In-services were provided to all nursing staff including RN's, LPN's, KMA, and SRNA's regarding professional nursing standards. This in-service was initiated on 2-28-15 by the DON, Staff Development Coordinator, and Nursing Supervisor and was completed on 3-2-15. The in-servicing included the professional nursing standards established in the Lippincott Manual of Nursing Practice pertaining to CPR, code blue documentation, honoring resident's advance directives, and the requirement to have a signed</p>	
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F 155	<p>Continued From page 29</p> <p>answers.</p> <p>Interview, on 03/06/15 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; 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</p>		<p>physician's order for "DNR" before withholding CPR. Upon completion of the re-education, a post test was administered to all nursing staff. For anyone found to have answered a question incorrectly, they were promptly re-in-serviced on the subject matter and asked to re-answer the question until they answered correctly. These records are maintained in the facility In-Service Post Test folder.</p> <p><i>Systemic Changes</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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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%.

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.

procedure. The in-service will cover the difference between a DNR and full code, how to identify a residents code status, procedure on how to call for and initiate a Code Blue, CPR, who should respond to a Code Blue immediately, where to locate the crash cart, contacting the medical doctor and dialing 911, to notify the Administrator and DON, and to document all details of the code in the medical record. Additionally, professional nursing standards as outlined in the Lippincott Manual of Nursing Practice and facility 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. The test will evaluate response time, accuracy in determining code-status of the mock resident, as well as adherence to the facility code-status policy and procedure. Results of this drill is being documented by the Staff Development Coordinator, QA nurse or DON and submitted to the DON and Administrator for review. Any staff members identified to not follow facility policy and procedure

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F 155	<p>Continued From page 31</p> <p>Interview with MR on 03/08/15 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.</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 03/08/15, 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, KMA's and SRNA's) did received education related to professional nursing standards, pertaining to provision of CPR, documentation, ensuring a</p>		<p>will be re-in-serviced on a one-on-one basis 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>Additionally, the results of these drills are being submitted by the Administrator or DON to the facility QAA meeting for interdisciplinary review.</p> <p>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').</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 are being</p>	

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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)	(X6) COMPLETION DATE
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F 155

Continued From page 32  
Physician's order for DNR status and honoring each resident's Advance Directives.

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 #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%.

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.

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

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.

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.

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. These carts are being checked Monday-Friday by the Central Supply Coordinator, and checked Saturday-Sunday by the House Supervisor. The

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165144	(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		
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F 155	<p>Continued From page 33</p> <p>drill went very well, and everyone seemed to be more comfortable with their role in a Code Blue event.</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 03/06/16 at 5:30 PM, with the SDC revealed a mock Code Blue drill would be completed quarterly on all shifts and on weekends.</p>		<p>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 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</p>	
F 279 SS=K	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided</p>			

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F 279	<p>Continued From page 34</p> <p>due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, review of the facility's policy and procedures it was determined the facility failed to have an effective system to ensure the Comprehensive Care Plan was developed related to residents' Advance Directives and code status for six (6) of eight (8) sampled residents (Residents #1, #2, #3, #4, #6, #7) to ensure the resident's code status was honored and Cardiopulmonary Resuscitation (CPR) was provided as requested when Resident #1 was found unresponsive on 02/18/15.</p> <p>Resident #1 signed a document on 09/11/12, requesting to have CPR provided in the event of cardiac or respiratory failure. However, review of Resident #1's Comprehensive Care Plan revealed no documented evidence of a care plan developed regarding the resident's requested Full Code status (a Full Code status indicates in the event of cardiac or respiratory failure, life-saving measures would be initiated) with interventions to address his/her code status.</p> <p>State Registered Nursing Assistant (SRNA) #1 found Resident #1 non-responsive on 02/18/15 at approximately 8:30 AM, and immediately notified Registered Nurse (RN) #1, who shook the resident and checked for a pulse and respirations. However, CPR was not initiated as the resident requested on 09/11/12. Another nurse, RN #2 came to Resident #1's room as requested by SRNA #1, and was informed by RN</p>		<p>Blue Protocol and post test and each licensed nurse must have a current CPR certification.</p> <p><b>Monitoring</b></p> <p>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 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.</p>	
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F 279	<p>Continued From page 35</p> <p>#1 the resident was a Full Code. However, she also did not immediately initiate CPR for Resident #1, and left the room to overhead page Licensed Practical Nurse (LPN) #1/Supervisor to come to Resident #1's room.</p> <p>Upon entering Resident #1's room, LPN #1/Supervisor, CPR was still not initiated and she told RN #1 and RN #2 they had to start CPR. However, she failed to ensure CPR was initiated, and left Resident #1's room to verify whether CPR should be performed on a Full Code resident who was non-responsive and was told "yes" it should be done. 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.</p> <p>The facility's failure to ensure residents' Comprehensive Care Plans were developed to include their requested code status with interventions in place to ensure their code status was honored 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</p>		<p>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.</p> <p>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). 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</p>		

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Continued From page 35  
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.

The findings include:

Review of the facility's policy titled, "Care Plans-Comprehensive," revised September 2010, revealed an individualized Comprehensive Care Plan was developed for each resident to include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. Continued review revealed each resident's Comprehensive Care Plan was designed to reflect the resident's expressed wishes regarding care and treatment goals, aid in preventing or reducing declines in the resident's functional status and/or functional levels. Further review revealed the Comprehensive Care Plan was to reflect currently recognized standards of practice for problem areas and conditions.

1. 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 Chronic Ischemic Heart Disease, Acute Respiratory Failure, Chronic Bronchitis and Chronic Airway Obstruction. Review of the Quarterly MDS Assessment dated 12/07/14, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15). Continued record review revealed Resident #1 had requested to be

supervisor. If any discrepancies are found, corrections will be made immediately. The audits are 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.

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. 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

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F 279	<p>Continued From page 37</p> <p>a Full Code and signed a document noting this on 09/11/12. However, review of the Comprehensive Care Plan (CP) dated 06/26/14, revealed no documented evidence a care plan was developed for Resident #1's Advance Directive and/or Full Code status with interventions to ensure the resident's request was honored.</p> <p>2. Review of Resident's #2 medical record revealed the facility admitted the resident on 12/12/14, with diagnoses which included Muscle Weakness, Diabetes, Depression, Hypertension, Chronic Airway Obstruction, Generalized Osteoarthritis and Dementia. Review of the Admission MDS Assessment dated 12/19/14, revealed the facility assessed Resident #2 as being moderately cognitively impaired, with a BIMS score of ten (10) out of fifteen (15). Continued record review revealed Resident #2 had Advance Directives dated 12/12/14, noting the resident did not want CPR. However, review of the Comprehensive Care Plan (CP) dated 12/19/14, revealed no documented evidence a care plan was developed for Resident #2's Advance Directive and/or Do Not Resuscitate (DNR) status with interventions to ensure the resident's request was honored.</p> <p>3. Review of Resident's #3 medical record revealed the facility admitted the resident on 11/18/05, and readmitted him/her on 11/09/12, with diagnoses which included Adult Failure to Thrive, Muscle Wasting, Senile Dementia, Anxiety Disorder and Psychosis. Review of the Quarterly MDS Assessment dated 01/14/15, revealed the facility assessed Resident #3 as being moderately cognitively impaired, with a BIMS score of nine (9) out of fifteen (15). Continued record review revealed Resident #3</p>		<p>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 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>	

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F 279	Continued From page 38 had Advance Directives dated 04/27/09, indicating he/she did not want CPR. However, review of the Comprehensive Care Plan (CP) dated 07/17/14, revealed no documented evidence a care plan was developed for Resident #3's Advance Directive and/or DNR status with interventions to ensure the resident's request was honored.  4. Review of Resident's #4 medical record revealed the facility admitted the resident on 11/20/14, with diagnoses which included Acute Respiratory Failure, Cerebrovascular Disease, Dementia, Depression and Anxiety. Review of the Quarterly MDS Assessment dated 01/17/15, revealed the facility assessed Resident #4 as being moderately cognitively impaired, with a BIMS score of twelve (12) out of fifteen (15). Continued record review revealed Resident #4 had Advance Directives dated 11/20/14, requesting to be a Full Code. However, review of the Comprehensive Care Plan (CP) dated 11/27/14, revealed no documented evidence a care plan was developed for Resident #4's Advance Directive and/or Full Code status with interventions to ensure the resident's request was honored.  6. Review of Resident's #6 medical record revealed the facility admitted the resident on 02/07/15, with diagnoses which included Contusion of Hip, Congestive Heart Failure, Anemia and Dementia. Review of the Admission MDS Assessment dated 02/14/15, revealed the facility assessed Resident #6 as being moderately cognitively impaired, with a BIMS score of ten (10) out of fifteen (15). Continued record review revealed Resident #8 had Advance Directives dated 02/07/15, indicating he/she did	F 309	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.  <i>Date of Correction:</i> March 24, 2015  F 309 D: Provide Care/Services for Highest Well Being  <i>Residents Affected</i> Resident #1, who implemented advance directive on 9-11-12, requesting to be a full code was found non-responsive on 2-18-15 by a SRNA. The SRNA notified the RN nurse caring for Resident #1. The RN assessed and found no vital signs but delayed the initiation of CPR. The SRNA went to get another nurse who checked his vital signs who then went to check his code status and get the unit supervisor. The unit supervisor instructed the two nurses to start CPR and she went to call 911. EMS arrived and continued the CPR until arrival at the hospital where Resident #1 was pronounced deceased.	3-24-15

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F 279	<p>Continued From page 39</p> <p>not want CPR. However, review of the Comprehensive Care Plan (CP) dated 02/14/15, revealed no documented evidence a care plan was developed for Resident #8's Advance Directive and/or DNR status with interventions to ensure the resident's request was honored.</p> <p>8. Review of Resident's #7 medical record revealed the facility admitted the resident on 02/10/15, with diagnoses which included Diabetes, Heart Failure, Congestive Heart Failure, Dysphasia and Cerebrovascular Accident. Review of the Admission MDS Assessment dated 02/17/15, revealed the facility assessed Resident #7 as being severely cognitively impaired, with a BIMS score of seven (7). Continued record review revealed Resident #7 had Advance Directives dated 02/10/15, noting the resident did not want CPR. However, review of the Comprehensive Care Plan (CP) dated 02/20/15, revealed no documented evidence a care plan was developed for Resident #6's Advance Directive and/or DNR status with interventions to ensure the resident's request was honored.</p> <p>Interview with RN #4/MDS Coordinator on 03/04/15 at 4:30 PM, revealed the Unit Manager placed residents' requested code status on the Nurse Aide Care Plans. However, residents' code status was never addressed on their Comprehensive Care Plans, although it should be a part of their care plan.</p> <p>Interview with LPN #2/MDS Nurse on 03/04/15 at 4:30 PM, revealed the facility placed residents' code status on their Comprehensive Care Plans now; however, had never addressed it on the CP prior to the survey. LPN #2/MDS Nurse stated</p>		<p><i>Identification/Protection of Other Residents</i></p> <p>On 2-18-15 and 2-19-15 licensed nurses including RN's, LPN's, KMA's and SRNA's were re-inserviced by the RN Staff Development Coordinator on immediately initiating CPR when a Code Blue is called, or when a resident is discovered without vital signs and has an advanced directive to start CPR immediately, and honoring each Resident Rights. The facilities Code Blue protocol was used for the in-service.</p> <p>Then beginning 2-27-15 and finishing on 3-2-15, all nursing staff which included RN's, LPN's, KMA's and SRNA's were re-educated by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and Nursing Supervisor on the difference between a DNR and full-code, how to identify a residents code status, procedure on 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, to notify the DON and Administrator, and to document all details of the code in the medical record. The in-servicing also included: In the event that a resident is found unresponsive the facility requires the following; Code blue may be initiated by an RN or LPN. Overhead page three (3) times CODE BLUE and room</p>	<p><i>done</i></p> <p><i>done</i></p>	

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F 279	<p>Continued From page 40</p> <p>residents' code status should be on their CP in order to honor each resident's wishes (In the event of respiratory or cardiac failure).</p> <p>Interview with the Director of Nursing (DON) on 02/26/15 at 3:25 PM and 6:05 PM, revealed residents' Advance Directives/Code Status should be care planned. Although the Nurse Supervisors put residents' code status on the nurse aide care plans, it had not been addressed on the Comprehensive Care Plans. Per interview, the facility's policy did not address requiring the Advance Directives/Code Status to be placed on residents' Comprehensive Care Plans.</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"> <li>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.</li> <li>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.</li> <li>On 02/18/15, the DON notified Resident #1's family of the delay in initiating a Code Blue by RN #1.</li> </ol>		<p>number or location (do not page resident's name). All available nursing staff must respond right away. Crash cart from the closest nursing station will be taken to location by any staff member at the nurse's station. Check code status (any staff member). An RN or LPN will assess resident for vital signs including: Respiration-rate and quality, Circulation, pulse, and blood pressure, Glucose level, if indicated, Blocked airway, choking and to immediately initiate CPR, if appropriate until EMS arrival. Contact medical doctor and/or send out 911. If a DNR and an RN determines that CPR should not be initiated, a Registered Nurse may pronounce death after obtaining vital signs X three (3) at five (5) minute intervals. Document the vital signs in the medical record, notify physician, family, and/or responsible party. Notify DON and Administrator. Lastly, document all details of the code in the medical record.</p> <p>Upon completion of the re-education, a post test was administered on Identification of the Code Status; Care Planning; Advance Directives; Resident Rights; Code Blue Documentation; and Code Blue Protocol to the nursing staff by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and the Nursing Supervisors.</p> <p>For anyone found to have answered a question incorrectly, they were</p>		

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F 279	<p>Continued From page 41</p> <p>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.</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</p>		<p>promptly re-in serviced on the subject matter and asked to re-answer the question until they answered correctly. These records are being maintained in the facility In-Service Post Test folder</p> <p>In-services were provided to all nursing staff including RN's, LPN's, KMA, and SRNA's regarding professional nursing standards. This in-service was initiated on 2-28-15 by the DON, Staff Development Coordinator, and Nursing Supervisor and was completed on 3-2-15. The in-servicing included the professional nursing standards established in the Lippincott Manual of Nursing Practice pertaining to CPR, code blue documentation, honoring resident's advance directives, and the requirement to have a signed physician's order for "DNR" before withholding CPR. Upon completion of the re-education, a post test was administered to all nursing staff. For anyone found to have answered a question incorrectly, they were promptly re-in-serviced on the subject matter and asked to re-answer the question until they answered correctly. These records are maintained in the facility In-Service Post Test folder.</p> <p><i>Systemic Changes</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</p>	<p><i>done</i></p>

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DON developed a reference book for Code Blue events, and placed a book on each crash cart.

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.

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.

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

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.

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.

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 procedure. The in-service will cover the difference between a DNR and full code, how to identify a residents code status, procedure on how to call for and initiate a Code Blue, CPR, who should respond to a Code Blue immediately, where to locate the crash cart, contacting the medical doctor and dialing 911, to notify the Administrator and DON, and to document all details of the code in the medical record. Additionally, professional nursing standards as outlined in the Lippincott Manual of Nursing Practice and facility policy and procedure on comprehensive care plans will be covered in these in-services. These in-services are scheduled for 4/6/15,

*NO Code Blue's since 3/29/15*  
*Done*

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F 279	<p>Continued From page 43</p> <p>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 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.</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</p>		<p>5/4/15, 6/1/15, 7/6/15, 8/3/15, and 9/7/15.</p> <p>A <i>mock Code Blue drill</i> 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. The test will evaluate response time, accuracy in determining code-status of the <i>mock resident</i>, as well as adherence to the facility code-status policy and procedure. Results of this drill is being documented by the Staff Development Coordinator, QA nurse or DON and submitted to the DON and Administrator for review.</p> <p>Any staff members identified to not follow facility policy and procedure will be re-in-serviced on a one-on-one basis 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>Additionally, the results of these drills are being submitted by the Administrator or DON to the facility QAA meeting for interdisciplinary review.</p> <p>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</p>	

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F 279	<p>Continued From page 44</p> <p>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> <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</p>		<p>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 march and that there were no discrepancies in the policy. This audit consisted of 100% of the facility's residents (128/128 residents).</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>	done

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F 279	<p>Continued From page 45</p> <p>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> <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</p>	<p>On 2-19-15, the DON developed a Code Blue reference book for each crash cart for the licensed nurses.</p> <p>On 2-19-15, the Central Supply Coordinator audited each of the six (6) code crash certs to validate that items were present and within expiration. The audit showed 6/6 crash carts were properly stocked with no expired equipment. 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.</p>	(X5) COMPLETION DATE  <i>done</i>

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F 279	<p>Continued From page 46</p> <p>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.</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>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 posttest; 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>	

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F 279	<p>Continued From page 47</p> <p>22. On 02/26/15, 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.</p> <p>23. Between 02/26/15 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.</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 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.</p> <p>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.</p> <p>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</p>	<p><i>done</i></p>

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F 279	<p>Continued From page 48</p> <p>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 procedures.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> <li>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.</li> <li>Interview, on 03/04/15 at 8:00 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.</li> <li>2. The State Survey Agency received the initial report regarding the delayed Code Blue event involving Resident #1 on 02/18/15.</li> <li>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.</li> </ol> <p>Phone contact was attempted with Resident #1's RP's family which was unsuccessful and a message was left. However, no return call was received.</p> <ol style="list-style-type: none"> <li>4. Review of the facility's in-service sign-in form</li> </ol>		<p>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).</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 are 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</p>

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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 279	<p>Continued From page 49</p> <p>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 #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>were present and within expiration. 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</p>
			(X5) COMPLETION DATE  <i>done</i>

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F 279	<p>Continued From page 50</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> <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</p>	F 514	<p>post tests for Professional Nursing Standards; Identifying Code Status and posttest; 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>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.</p> <p><i>Date of Correction:</i> March 24, 2015</p> <p>F 514 D: Resident Records; complete, accurate, accessible</p> <p><i>Residents Affected</i> Resident #1, who implemented advance directive on 9-11-12, requesting to be a full code was found non-responsive on 2-18-15 by a SRNA. The SRNA notified the RN nurse caring for Resident #1. The RN</p>	3-24-15

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F 279	<p>Continued From page 51</p> <p>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 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</p>		<p>assessed and found no vital signs but delayed the initiation of CPR. The SRNA went to get another nurse who checked his vital signs who then went to check his code status and get the unit supervisor. The unit supervisor instructed the two nurses to start CPR and she went to call 911. EMS arrived and continued the CPR until arrival at the hospital where Resident #1 was pronounced deceased.</p> <p><i>Identification/Protection of Other Residents</i></p> <p>On 2-19-15, The Medical Records Coordinator audited 100% of the 128 residents' code status including: MD orders, care plan, SRNA care plan and DNR identification. The Medical Records Coordinator added each residents DNR and Full Code status to each resident's care plan.</p> <p>On 2-19-15, the Medical Records Coordinator and the Regional Director of Clinical Services audited all of the 50 residents who had expired at the facility during RN #1's employment; which was from 12-4-2012 thru 2-21-15, to determine if she had been involved in any other Code Blue emergencies. There were no findings that RN #1 had been involved in any other Code Blue while at Homestead, except for Resident #1. In fact, of the 50 deaths determined to have occurred</p>	

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F 279	<p>Continued From page 52</p> <p>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 Medical Director, Administrator, DON, QA Nurse, RDCS, RDO, UMs and SDC.</p> <p>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 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</p>		<p>during RN #1's employment, RN #1 had worked for 21 of them, and of the 21 all were DNR except for the event with Resident #1 on 2-18-2015.</p> <p>An audit was initiated and completed on 2-19-15 by 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).</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 will be conducted on the weekends by the weekend house supervisor 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</p>	

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F 279	<p>Continued From page 53 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, 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</p>		<p>frequency of continual auditing to maintain future compliance. If any discrepancies are found, corrections will be made immediately. The audits are being submitted to the DON daily for review. In addition, the results of these audits are being submitted by the DON to the QA. A monthly meetings for review and recommendations.</p> <p>Beginning 2-27-15 and finishing on 3-2-15, all nursing staff which included RN's, LPN's, KMA's and SRNA's were re-educated by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and Nursing Supervisor on the difference between a DNR and full-code, how to identify a residents code status, procedure on 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, to notify the DON and Administrator, and to document all details of the code in the medical record. The in-servicing also included; In the event that a resident is found unresponsive the facility requires the following; Code blue may be initiated by an RN or LPN. Overhead page three (3) times CODE BLUE and room number or location (do not page resident's name). All available nursing staff must respond right away. Crash cart from the closest nursing station</p>	

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F 279	<p>Continued From page 54</p> <p>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 03/05/15 at 8:30 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 8:30 PM, with the DON revealed the audit results were reviewed and</p>		<p>will be taken to location by any staff member at the nurse's station. Check code status (any staff member). An RN or LPN will assess resident for vital signs including: Respiration-rate and quality, Circulation, pulse, and blood pressure, Glucose level, if indicated, Blocked airway, choking and to immediately initiate CPR, if appropriate until EMS arrival. Contact medical doctor and/or send out 911. If a DNR and an RN determines that CPR should not be initiated, a Registered Nurse may pronounce death after obtaining vital signs X three (3) at five (5) minute intervals. Document the vital signs in the medical record, notify physician, family, and/or responsible party. Notify DON and Administrator. Lastly, document all details of the code in the medical record.</p> <p>Upon completion of the re-education, a post test was administered on Identification of the Code Status; Care Planning; Advance Directives; Resident Rights; Code Blue Documentation; and Code Blue Protocol to the nursing staff by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and the Nursing Supervisors. For anyone found to have answered a question incorrectly, they were promptly re-instructed on the subject matter and asked to re-answer the question until they answered correctly. These records are being</p>	
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F 278	<p>Continued From page 55 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, 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 03/08/15 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 03/08/15 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>maintained in the facility In-Service Post Test folder.</p> <p>On 2-27-15 thru 3-2-15, re-inservicing was initiated for all staff from each Department, including, Nursing, Dietary, Maintenance, Social Services, Activities, and Housekeeping regarding Advance Directives and Resident Rights and all in-services were completed on 3-2-15. The in-servicing was conducted by the DON, Social Services Director, Staff Development Coordinator, Quality Assurance Officer, and Nursing Supervisor. After the in-service each employee was given a post test on advance directives and resident rights. For anyone found to have answered a question incorrectly, they were promptly re-inserviced on the subject matter and asked to answer the question until they answered correctly.</p> <p>In-services were provided to all nursing staff on 2-27-15 which included RN's, LPN's, KMA's and SRNA's, regarding comprehensive care plans which should include each resident's advance directive decisions. This in-service was conducted by the DON, Staff Development Coordinator, and Nursing Supervisor and was completed on 3-2-15. Of the two (2) employees on leave, which we were unable to get in contact with, will not be added to the schedule until in-services are completed and a post test</p>		

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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 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.

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,

is conducted to determine competency. The in-servicing included the facility policy and procedure related to comprehensive care plans, with special focus on the revision to include code status and advance directives in the comprehensive care plan.

Upon completion of the re-education, a post test was administered to all nursing staff by the DON. For anyone found to have answered a question incorrectly, they were promptly re-in-serviced on the subject matter and asked to re-answer the question until they answered correctly. These records are maintained in the facility In-Service Post Test folder.

**Systemic Changes**

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.

Results of the investigation will be submitted to the QAA monthly meeting by the DON. There has not

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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 1808 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 57</p> <p>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 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 03/08/15, 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 #6; 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 #8; 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</p>		<p>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 procedure. The in-service will cover the difference between a DNR and full code, how to identify a residents code status, procedure on how to call for and initiate a Code Blue, CPR, who should respond to a Code Blue immediately, where to locate the crash cart, contacting the medical doctor and dialing 911, to notify the Administrator and DON, and to document all details of the code in the medical record. Additionally, professional nursing standards as outlined in the Lippincott Manual of Nursing Practice and facility 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.</p> <p>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. The test will evaluate response time, accuracy in determining code-status of the mock</p>

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F 279	<p>Continued From page 58</p> <p>LPN #3; at 4:30 PM with SS #13; at 4:40 PM with SRNA #9; and at 4:50 PM with RN #8 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 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>resident, as well as adherence to the facility code-status policy and procedure. Results of this drill is being documented by the Staff Development Coordinator, QA nurse or DON and submitted to the DON and Administrator for review.</p> <p>Any staff members identified to not follow facility policy and procedure will be re-in-serviced on a one-on-one basis 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>Additionally, the results of these drills are being submitted by the Administrator or DON to the facility QAA meeting for interdisciplinary review.</p> <p>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). There were no corrections needed from these audits but the facility will</p>	
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