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	145234	A. BUILDING _____ B. WING _____	C 09/15/2005

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F 309	Continued From page 8 procedure and method of determining resident code status. The DON will also review the CPR certification of new hires and schedule training if indicated at the time of hire. 4. The CPR policy was amended to include the tasks to be accomplished in conjunction with CPR. This was amended on 9/14/05 and re-education initiated. 5. The facility continues to provide ongoing education and has developed a QA tool that will be done randomly each week for nursing staff to validate that staff are aware of the CPR policy and procedure and the role of all staff in the procedure. This was developed and implemented 9/14/05. Any concerns identified will be brought to the administrator for review and concerns will be discussed with the QA Committee for resolution and corrective action when indicated.	F 309		
F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH THIS SURVEY: 300.610 a) 300.1210 a) 300.1210 b)2 300.3240 a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician, or	F9999		

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the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated there under. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident ' s comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: All treatments and procedures shall be administered as ordered by the physician.

An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by interviews and record review the facility failed to:
[1] Follow doctor ' s orders and initiate cardiopulmonary respirations (CPR) on R1 when he was found unresponsive 7/16/05,
[2] Educate new staff on the cardiopulmonary resuscitation (CPR) protocol, ensuring staff are knowledgeable on how to identify a resident who

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is a full code or do not resuscitate (DNR), and [3] Ensure that the facility policy for marking charts to indicate code status is followed and that the physician order sheets match the indicators of code status (orange sheet, wrist band, color of the chart) on each resident/resident chart.

These observations effect 1 of 35 residents in the facility with a full code status that did not receive cardiopulmonary resuscitation (CPR) - R 1 and 24 residents with unclear indicators of code status: 11 of 35 residents who have are " full code " - R6, R8, R9, R12, R15, R16, R21,R22, R 24, R29, R30 and 13 of 73 residents who are do not resuscitate (DNR) - R4, R5, R7, R10, R11, R 13, R14, R17, R18, R19, R20, R23, R25.

The examples include:
[1] The physician order sheet (POS) for R1, dated 7/1/05, documented diagnoses including Laryngeal Cancer, Dysphagia, Tracheostomy, Congestive Heart Failure and Atrial Fibrillation. The POS for R1 dated 7/1/05 documented, "Full Code."

The nurses notes dated 7/14/05 at 2PM stated, " R1 arrived per ambulance.... R1 opens eyes when name is called otherwise not oriented to person, place or time. Very restless in bed. Pulls at oxygen tubing, tracheostomy, urinary catheter and feeding tube." The nurse ' s notes dated 7/ 16/05 on PMs state, "Mucous is frothy brownish color. Appears to be resting comfortably at this time after oxycodone was administered... [18:45] Resting quietly condition unchanged. [19:45] Discovered respirations have ceased. No apical pulse. No blood pressure. Pupils are fixed and dilated. No code initiated due to obvious death -

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F9999	Continued From page 11 unwitnessed. Oxygen saturation 0%." On 8/16/05 at 8:10AM, E1 (Administrator) stated, "R1 had throat cancer, end of life. R1 had a lot of things wrong with him. The certified nursing assistant (CNA) did rounds on him at 7PM and thought he was dead. The CNA went and got the nurse. I have a statement from her. The nurse started assessing R1 and told the CNA to go and get the floor nurse. The floor nurse assessed R1 and found no evidence of life. R1 was a full code and they did not start CPR." On 8/16/05 at 2:50PM, E7 (CNA) stated, "I didn't work that wing that night. I was looking for E6 (CNA). I peaked in R1's room, it looked like R1 wasn't breathing. I ran out to get E5 (LPN). E5 went and checked a carotid pulse. E5 ran out and got the other nurse. E4 (RN) checked R1 with her stethoscope for an apical pulse. E5 said he was gone. E5 said R1 was a full code but that he was better off dead. E5 then took all of his tubing out. R1 wasn't purple, he looked peaceful. R1 was still warm. R1 had just been turned at 7 PM. When I saw R1 at 7:45 his color was fine, not purpled. R1 wasn't mottled. I don't know why E5 didn't code him. Maybe because of how sick he was." Review of the facilities CPR log documented E7 as certified until 2/06 in CPR. On 8/16/05 at 12:55PM, E5 (LPN) stated, "E7 went in to reposition R1 and came out and said she thought he was gone. I went in and listened for an apical pulse and told E7 to get the other nurse. I don't really remember because it's a blur . R1 was cool and his mouth was open." When E5 was asked if she knew R1 was a full code she stated, "Yes, I was. I was working the other wing.	F9999		

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I guess it's common sense if they are a full code to code them." E5 stated she had not been working at the facility that long and was not familiar with the facility's CPR policy. Review of the facility's CPR log documented E5 as certified in CPR until 2/07.

During an interview conducted on 8/19/05 at 11: 05AM, E4 (RN) stated, "I worked the 10-6 shift part time. I worked Friday night. I told the DON I was not familiar with the PM shift. I agreed to work 7PM to 6AM shift the next day. I knew R1 was not in good shape. R1 had morphine sulfate at 6:15PM. At 7:45PM I was called by E5 and she stated, "I think R1 is dead." R1's pupils were dilated and his lenses had started to crinkle. I knew R1 was a full code. R1 had a lot of mucous in his lungs. R1 had methicillin resistant staff aureus (MRSA) in his lungs. R1 was dead for 45 minutes to an hour. I was an emergency medical technician (EMT) on an ambulance so I knew he was dead. R1 had started to turn cold so I hesitated to do CPR. I couldn't be in R1's room every 5 minutes. The family was accepting of his death. R1 shouldn't have been admitted to the facility, he had a lot of problems. The doctor concurred to not do CPR. I guess the facility thought I should have done a code. R1 was very sick. R1's abdomen was cool and limbs were cold. R1's pupils had set and crinkled." The facilities CPR log documented E4 as certified in CPR until 4/07.

The physician telephone orders for R1 dated 7/16 /05 documented, "Pronounced dead per telephone by doctor. May release the body...."

The Medical Certificate of Death for R1

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F9999	Continued From page 13 documented the immediate cause of death as Squamous Cell Carcinoma of the larynx. The facility policy dated 3/23/01 on CPR stated, " Rule: Begin cardio-pulmonary resuscitation immediately if the resident has no pulse, no respiration and unresponsiveness." [2] An interview was conducted on 8/16/05 at 8: 10AM, E1 (Administrator) stated, "The DNR and code status is in the chart." On 8/16/05 at 8:54 AM E9 (Licensed Practical Nurse - LPN) stated, " We know who is a full code or DNR at first glance by looking at the different colors on the spine of the chart. The orange ones mean DNR and the white is a full code. There are code orders on the physician order sheet (POS). We have a bracelet system. It is a clear bracelet if the resident is a full code. No bracelet is worn if they are a DNR." On 8/16/05 at 3:50PM E10 (LPN) stated, "I know who is a full code or DNR by the color of the chart. A full code is white and a DNR is orange. The code status is also documented on the POS. There are no bands on the residents that let you know if they are a DNR or full code." On 8/18/05 at 8:10AM, E3 (Assistant Director of Nursing-ADON) stated, "The orange on the chart means they are DNR. The white on the chart means they are a full code. There is also an orange sheet in the chart stating the DNR status. The code status is also in the chart on the POS. The POS will state whether they are a DNR or full code. We were doing the clear bracelet to show who is a full code. I don't know if the newer residents have them. I'm just not sure if we are	F9999		

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F9999	Continued From page 14 up-to-date." On 8/18/05 at 8:20AM, E1 (Administrator) stated, "I don't think we are putting clear bracelets on residents any more. I'm not sure. I'll have to check with E3 (ADON) and nursing. The nurses know they have to check the chart." On 8/18/05 at 8:35AM, E3 dated, "I guess we aren't using the clear bracelets anymore. But I guess you already knew that." On 8/16/05 at 10:30AM all of the first floor residents' charts were reviewed. Thirty-five resident charts had orange on the spine of their charts indicating a status of DNR. Nineteen residents had white on the spine of their charts indicating they were a " full code " . [A] R5, R7, R10, R11 had orange on the spine of their charts (indicating a status of DNR). R5 had DNR handwritten on the 8/1/05 POS with no signature for the order. R5's 6/1/05 POS had no DNR order. R7's POS dated 6/1/05, 7/1/05 and 8/1/05 did not have DNR orders. R10's POS dated 7/1/05 and 8/1/05 did not have DNR orders . R11's POS dated 6/1/05, 7/1/05 and 8/1/05 did not have DNR orders. [B] R6, R8, R9, R12, R15, R29 and R30 had white on the spine of their charts indicating they were a " full code " . There were no orders on the 8/1/05 POS' for R6, R8, R9, R12 and R15 stating a code status. R29 and R30 had living wills and POS' dated 8/1/05 documenting a DNR code status. [C] On 8/18/05 at 8:35AM E3 reviewed the charts for R9, R10 and R29. E3 confirmed R9 did not have any code orders on the 8/1/05 POS; R10 had orange on the spine of the chart, a	F9999		

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F9999	Continued From page 15 signed DNR form and no DNR order on the 8/1/ 05 POS; R29 had white on the spine of the chart, a living will in the chart and the 8/1/05 POS had a DNR order. On 8/16/05 at 1:00PM all of the second floor resident's charts were reviewed. Forty resident charts had orange on the spine of their charts indicating a status of DNR. Twelve residents had white on the spine of their charts indicating they were a " full code " . [A] R4, R13, R14, R17, R18, R19, R20, R23 and R25 had orange on the spine of their charts (indicating a status of DNR). The POS' dated 6/1/ 05, 7/1/05 and 8/1/05 for R4, R14, R18, R23 and R25 did not have DNR orders. The POS dated 7/ 1/05 and 8/1/05 for R19 did not have DNR orders . The POS' dated 6/1/05, 7/1/05 and 8/1/05 for R 13 and R20 had orders stating "full code." The POS' dated 7/1/05 and 8/1/05 for R16 had orders stating "full code." [B] R15, R16, R21, R22 and R24 had white on the spine of their charts (indicating they were a " full code "). There were no orders on the 8/1/05 POS' for R15, R16, R21 and R24 stating a code status. [C] On 8/18/05 at 8:50am, E3 (Assistant Director of Nursing-ADON) confirmed R13 had orange on the spine of her chart, an orange DNR sheet and a POS dated 8/1/05 documenting the resident is a full code. E3 stated, "I guess we need to do a chart audit." (A)	F9999		