| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145610 | A. BUILDING _____ B. WING _____ | C 11/01/2006 |

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| F9999 | Continued From page 13<br>Licensure Violations:<br><br>300.610a)<br>300.1210a)<br>300.1210b)2)<br>300.1210b)3)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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 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 thereunder. 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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) 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.<br><br>b)2) All treatments and procedures shall be | F9999 | | |

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| F9999 | Continued From page 14<br>administered as ordered by the physician.<br><br>b)3) Objective observations of changes in a resident ' s condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident ' s medical record.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These regulations were not met as evidenced by the following:<br><br>Based on interview and record review three facility staff neglected to activate the emergency medical response system and initiate emergency resuscitation measures as required by facility policy for 1 of 10 residents sampled for Advanced Directives (R3).<br><br>Three facility staff found R3 non-responsive on 10/19/06 at 11:00 PM and failed to respond as required by facility policy. These three staff members also failed to honor R3's Advanced Directive request that he be resuscitated.<br><br>Findings include:<br><br>R3's October 2006 Physician's Orders indicated he was born on 3/16/61 and that he was 45 years old. Review of the orders also showed R3 is a "Full Code (meaning he is to receive full cardiopulmonary resuscitation efforts in the event | F9999 | | |

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| F9999 | Continued From page 15<br>he becomes non-responsive)." The orders indicated R3 had diagnoses of Insulin Dependent Diabetes Mellitus, Congestive Heart Failure, and Chronic Renal failure. R3's most recent assessment, dated 10/17/06, showed R3 was independent in Decision Making and Cognitive Function. It also showed R3 needed only supervision and set-up help in all other activities of daily living and that R3 was continent of both bowel and bladder. Interviews with E1 through E8 on various days and at various times throughout the survey indicated R3 was independent in action and thought, and came and went from the facility as he wished.<br><br>E4, Certified Nursing Assistant (CNA), in an interview on 10/25/06 at approximately 3:00 PM stated, "I was the CNA who found (R3) on 10/19/06, a Thursday. When I found (R3) he was sitting on the toilet slumped against the wall. His right side and right head was leaning against the wall. His right arm was hanging down and his left arm was up on his leg. His face was pale and he was not moving. I did not touch him (at the time) until I went back in (after summoning help), he (R3) was not cold. His body was not stiff. When I first saw him on the toilet I went out the door and waved at (E7) (Licensed Practical Nurse, LPN) to come quick. (E7) went into the bathroom by herself. I was shaky and was standing against the wall outside the bathroom. (E7) told me to go get (E1) (Administrator). When I went to get (E1) she was coming out of her office, I told her (R3) looked like he was gone. I did not know his code status and I did not go look for his chart to find out. At that time I did not even think about doing CPR (Cardiopulmonary Resuscitation) on (R3)." | F9999 | | |

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| F9999 | Continued From page 16<br>E7, LPN, stated in an interview on 10/25/06 at approximately 2:00 PM, that R3 had been found non-responsive on 10/19/06 and that she neglected to follow facility policy by failing to initiate CPR. E7 stated, "I was here (at the facility) working the night (R3) was found dead in the bathroom. He was found at 11:00 PM on 10/19/06 by (E4). I came on at 10:00PM, and I relieved (E6 LPN). I examined him (R3) and he had no pulse and was not breathing; (I found out later) he was a full code. I did not start CPR. I was supposed to start CPR. We should have started CPR but did not. He (R3) was still warm except his left arm was cold. His left arm could not be straightened at the elbow."<br><br>E6, LPN, on 10/26/06 at approximately 1:40 PM demonstrated she was present during the time R3 was found non-responsive. E6 also indicated she did not follow facility policy to activate the EMS (Emergency Response System) by calling 911 or starting CPR. E6 stated, "...I gave report to (the) night shift nurse and we did the count (narcotic count). E3 brought to (E7's) attention that she (E7) was needed by (E4) down the hall. (E7) went down. I said 'What's wrong?' (E3) said they found him (R3). That's when I went down to the bathroom. I went into the bathroom and (R3) was on the toilet...I checked for a pulse. I asked for someone to bring a stethoscope; someone brought one and I could not hear any heart sounds. I went up to E1's office. Later on I asked E7 what R3's code status was. E7 said he (R3) was a full code. I told E1 and E7 both that we should have started CPR because he was a full code. (When E6 examined R3) he (R3) was limp and he was not cold to the touch. His face was pale. The whole scene was eerie, (E7) was cool and collected and (E4) was hysterical...." | F9999 | | |

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| F9999 | Continued From page 17<br><br>E3, CNA, in an interview on 10/26/06 at approximately 5:00 PM stated "I came in at 10:00 PM on 10/19/06. I went to the laundry room to check linen. I then answered another call light. When I finished I was leaving the room and heard some yelling. I went to where other staff was going in response to the "STAT" (immediate response required) call. When I got to the bathroom the night nurse, night CNA, and evening nurse were in there. I saw (R3) on the toilet. (R3) was leaning against the wall, arms to his side, face white as a sheet. The Administrator was there within a few minutes of finding (R3). E1, Administrator, said, "his legs are still warm. Have E6 come back and take vitals again...."<br><br>Interview with Z1, Physician, by telephone on 10/25/06 at approximately 2:10 PM confirmed R3 was a full code and CPR should have been started. "On Thursday night 10/19/06 I was notified and was told it looked like he (R3) had passed away. I drove to the facility. I checked him, (he had) no pulse, no respirations. The cause of death was Cardiac Arrhythmia secondary to End Stage Renal Disease, tertiary to Diabetes Mellitus. I had talked to (R3) about his code status and he wanted to be a full code. It would have been appropriate (for staff) to do CPR. The nurses should have moved ahead and tried to do something for him (R3)."<br><br>Facility documents titled "Supervisor Report of Counsel" dated 10/25/06 for E7 and 10/26/06 for E6 demonstrate they were disciplined for this incident. The reports state, "Failure to provide care as outlined by physician order and resident plan of care, not following policy and procedures | F9999 | | |

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| F9999 | Continued From page 18<br>DNR, advance directives, emergency care...." The reports go on to say E7 & E6 failed in "not providing the highest level of nursing care during an emergency situation...." The reports are signed by the Administrator, the Director of Nurses, and E7.<br><br>Review of a facility policy titled, "Cardiopulmonary Resuscitation" and identified by the Administrator as the policy in effect on 10/19/06 showed the following: "It is the policy of (The Facility) that cardiopulmonary resuscitation (CPR) shall be initiated and maintained by qualified staff, in cases of recognized cardiac and/or pulmonary arrest to sustain or support a resident's cardiac and/or pulmonary function until advanced life support systems are available. Cardiopulmonary Resuscitation shall be initiated on all residents except those who have designated through advanced directives and/or have a specific physician order for "DNR" (Do Not Resuscitate), "No Code" (Do Not resuscitate), or "No CPR." All employees of this facility shall be certified in CPR within a reasonable time after hire and annually thereafter." Further review of this policy showed comprehensive direction to staff of the particulars of CPR, Rescue Breathing, and other emergency life threatening situations.<br><br>(A) | F9999 | | |