MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38BH	A. BUILDING: _____ B. WING _____	C 08/29/2019

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DIVERSICARE OF MERIDIAN	4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) survey for CI MS #16183, that began on 8/26/2019, and concluded on 8/29/2019. The State Agency (SA) substantiated the complaint for not providing continued Cardiopulmonary Resuscitation (CPR) on a resident with a documented full code status. During the investigation, the SA found that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M500. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 8/15/2019, regarding the noncompliance of an Advance Directive by failing to continuously provide Cardio-Pulmonary Resuscitation (CPR), via the American Heart Association (AHA) recommendations, for Resident #1, who had a full code status. Resident #1 was found unresponsive and with no pulse at 10:30 PM on 8/15/2019. Staff initiated CPR, however CPR was not continued until Emergency Medical Services (EMS) arrived. The facility also failed to develop an accurate Baseline Care Plan for Resident #1, regarding the Advance Directive for a full code. The failure to provide CPR and the noncompliance with the Advance Directive resulted in the resident's death and placed other residents with a full code status in a situation that was likely to cause serious injury, harm, impairment, or death. On 8/27/2019 at 4:10 PM, the SA notified the facility of the IJ and SQC. The IJ and SQC existed at:	M 000		

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M 000	Continued From page 1 M500-Resident Rights The facility submitted an acceptable Removal Plan on 8/28/2019, in which the facility alleged all corrective actions were completed on 8/27/29, and the IJ removed on 8/28/2019. The SA validated the facility's Removal Plan on 8/29/19 and determined the IJ was removed on 8/28/2019, prior to exit. Therefore, the scope and severity for M500 was lowered from a "level IV" to a "level II", while the facility develops and implements a plan of correction and monitors the effectiveness of the systematic changes to ensure the facility sustains compliance with regulatory requirements. The facility held a license for 120 beds and had a census of 92.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for	M 500		9/22/19

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M 500	Continued From page 2 services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule,	M 500		

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M 500	Continued From page 3 regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;	M 500		

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M 500	Continued From page 4 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available	M 500		

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M 500	Continued From page 5 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on Record Review, Facility Policy Review, Resident's Responsible Party (RP) Interview, and Staff Interview, the facility failed to continuously provide Cardio-Pulmonary Resuscitation (CPR), per American Heart Association guidelines, on Resident #1, who had an Advance Directive for a full code status, for one (1) of five (5) resident records reviewed. Resident #1 was found unresponsive, with no pulse at 10:30 PM on 8/15/2019, by Certified Nursing Assistant (CNA) #1. CNA#1 began CPR on Resident #1, but stopped. Licensed Practical Nurse (LPN) #1 began CPR, but didn't continue until Medical Services (EMS) arrived. Resident #1 expired prior to Emergency arrival to EMS the facility, and without a physician's order. Resident #1's Responsible Party (RP) and the Emergency Medical Technicians (EMTs) reported that no one was performing CPR when they arrived. The failure to continuously provide CPR until the arrival of the Emergency Medical Technicians (EMTs), despite Resident #1's Full Code status Advance Directive, resulted in the resident's death and placed other residents with a full code status in a situation, which was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 8/15/19, when the facility failed to continue CPR on Resident #1, who had an Advanced Directive of Full Code Status, resulting in the death of Resident #1.	M 500	1. The resident has already expired and discharged from the centers documentation system. 2. All residents have the potential to be affected by this deficient practice, therefore all charts were checked. 3. Licensed Practical Nurse (LPN) #1 was suspended pending investigation on August 16, 2019 and LPN #1 was terminated on August 27, 2019. Mississippi Board of Nursing was notified on August 27, 2019 by the Administrator of the LPN#1 suspension and termination. Director of Nursing Services (DNS) completed 100% audit on August 16, 2019 of residents' charts to verify all advanced directives and code status orders were in place and accurate based upon the physician order. Finding of the audit revealed every resident had the correct code status in the physicians order in the computer. Director of Nursing Services (DNS) completed 100% audit of residents' charts for designated Resuscitation Order form in front of chart on August 16, 2019. Beginning August 16, 2019 and ending August 19, 2019, DNS educated Registered Nurses (RN), Licensed Practical Nurses (LPN) and Social Service Coordinator (SSC) on centers Cardio Pulmonary Resuscitation Policy (CPR) and Emergency Operations Plan Training	

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M 500	Continued From page 6 The facility's Administrator was notified of the IJ and SQC on 8/27/19. The facility submitted an acceptable Removal Plan on 8/28/2019 at 4:29 PM, in which the facility alleged all corrective actions to remove the IJ were completed on 8/27/19, and the IJ removed on 8/28/2019. The SA validated the facility's Removal Plan on 8/29/2019, and determined the IJ to be removed on 8/28/2019, prior to exit. Therefore, the scope and severity for: 42 CFR(s): 483.24(a)(3)-Cardio-Pulmonary Resuscitation (CPR), (F678) was lowered from a scope and severity of "J" to a scope and severity of a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility policy titled, "Cardio Pulmonary Resuscitation Policy," dated December 2018, revealed that it is the policy of this facility that basic life support, including initiation of Cardio-Pulmonary Resuscitation (CPR), is provided to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) who do not show obvious clinical signs of irreversible death, (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition) and in accordance with the resident's Advance Directive, any related physician order, such as code status, or in the absence of advance directives, or a Do Not Resuscitate (DNR) order. The policy's procedural guidelines documented that CPR will be initiated when CA (cardiac arrest) occurs for residents who have requested CPR in their Advance	M 500	Guide to include announcing Code Blue, correctly responding, performing CPR and continuing CPR until EMS arrives and begins care or a physician in attendance and gives order to cease CPR. Beginning August 16, 2019 and ending August 19, 2019, DNS educated RNs, LPNs, and SSC on centers Advance Directive Policy. Director of Clinical Education will train new LPNs and RNs on Cardio Pulmonary Resuscitation Policy to include correctly responding, performing CPR and continuing CPR until Emergency Medical Services (EMS) arrives and begins care or a physician in attendance and gives order to cease CPR and Advanced Directive Policy on hire during readmissions or new Code status changes will be checked the next day for accuracy. 4. Director of Nursing Service and / or Administrator will conduct post CPR reviews on any charts of resident who may have required CPR x three months. Beginning August 16, 2019 and ending August 22, 2019, one CPR code drill was conducted daily on various shift to include correctly responding to Code Blue being called, all Licensed Practical Nurses to be in room, performing CPR and continuing CPR until EMS arrives and begins care or a physician in attendance and orders are given to cease CPR. Beginning August 27, 2019 and end September 15, 2019, Director of Nursing Services, Unit Manager and / or Registered Nurse conducted CPR drills once weekly x three	

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M 500	Continued From page 7 Directives. The guidelines documented that the Resident's code status will be designated prominently in the front of the resident's chart. Review of the facility policy titled, "Advance Directives," dated November 1, 2016, revealed the facility recognizes the right of each Resident to issue Advanced Directives regarding his or her health care. The policy documented that Advanced Directives that comply with state law, and are consistent with the level of care the facility is licensed to provide, will be honored. The facility policy states that for the purpose of this policy, "Advance Directive" means a living will or durable power of attorney for health care, recognized under State law relating to the provisions of health care when a Resident is incapacitated. The facility policy's procedural guidelines documented that the facility will document in the Resident's medical record whether or not the Resident has executed an Advance Directive. Review of the facility's employee training document titled, "Emergency Operations Plan Training Guide", no date, revealed that the facility's Nursing department has designated the following "Code" words to notify team members of certain types of emergencies over the public address system. The training document noted that all other types of emergencies will be announced using plain language. The training document listed "Code Blue" as the Cardiac Arrest/Medical Emergency code. Review of the American Heart Association Guidelines, 2015, revealed CPR is initiated unless a valid DNR order is in place; obvious signs of irreversible death (rigor mortis, dependent lividity, decapitation, transection, or	M 500	weeks and monthly thereafter x three months. Administrator or Director of Nursing Services will report findings to centers Quality Assessment Performance Improvement Committee (QAPI) which is comprised of: Administrator, Medical Director, Director of Nursing Services and three other department heads monthly. The committee will review the results for additional monitoring, continued improvement and make recommendations as needed.	

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decomposition) are present; or initiating CPR could cause injury or peril to the rescuer. The guidelines note that staff must provide and continue CPR, prior to the arrival of Emergency Medical Services (EMS).

Review of a facility document titled, "Progress Notes," dated 08/15/2019, revealed that Licensed Practical Nurse (LPN) #1 entered a General Note at 11:34 PM. The note documented that a CNA (not named) stated Resident #1 was put to bed around 7:30 PM, at approximately 8:30 PM, LPN #1 went in to give the resident medication. The note documented the following: At approximately 8:55 PM, CNA rounded and stated the Resident was fine. CNA did rounds at approximately 10:30 PM, came back to nurses' station and stated the resident was not responding. A Code (Blue) was called. CPR performed. Vital signs not registering. Coroner called by ambulance services, funeral home notified. The progress note was electronically signed by LPN #1.

Review of a written report from Resident #1's family member, dated 8/22/19, revealed a concern that facility staff started CPR on Resident #1 and didn't continue until EMS arrived. The family member documented that when she walked into Resident #1's room, the nurse was standing there, and when asked why wasn't she doing anything, the nurse replied, "She's a DNR right?". The family member documented that she informed the nurse that Resident #1 was a full code. The family member documented there was clearly no Code (CPR) performed on Resident #1.

Review of the facility's investigative report, dated 8/16/19, revealed an allegation from Resident #1's Responsible Party and her daughter. The

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investigative report documented a concern that CPR was stopped too soon on Resident #1. The investigative report concluded that LPN #1 initiated CPR on the resident and then stopped when the family came into the room. The report documented that LPN #1 was suspended, reported to the Board of Nursing, and terminated.

Review of the facility's report to the Board of Nursing, dated 8/27/19, revealed LPN #1 was suspended, pending investigation, on 8/16/19. The report noted: "Nurse acted outside her scope and discontinued CPR without a physician order". The decision was made to terminate LPN #1, effective 8/27/19.

Review of Resident #1's medical records revealed a document titled, "Resuscitation Orders," dated 8/13/2019. The orders revealed that Resident #1's Responsible Party (RP), her daughter, signed the form indicating that in the event of a cardiopulmonary arrest, cardio-pulmonary resuscitation will be performed. The Resuscitation Order was also marked by Resident #1's RP, to indicate that in the event of a cardiac arrest and/or respiratory arrest, to initiate Cardio Pulmonary Resuscitation (CPR).

Review of Resident #1's August 2019's Physician's Orders revealed there were no orders for a Do Not Resuscitate (DNR).

During an interview, on 8/26/2019 at 10:45 AM, the Director of Nursing (DON) revealed that she had been made aware of the incident that occurred on 8/15/2019, concerning Resident #1 (not having continued CPR). The DON stated Resident #1's Advance Directive documented the Resident was a full code. She stated she didn't know why there was a DNR on the summary in

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the Baseline Care Plan, and didn't know who would have put it on the summary. The DON stated that she had begun to educate the nursing staff on the American Heart Association (AHA) recommendations for performing CPR until the Emergency Medical Technicians (EMTs) arrive and take over. The DON also stated that she had begun to in-service the nursing staff on Resident's Advance Directives, Code Statuses, and Base Line Care Plans. The DON stated that until in-serviced, the Nursing Staff would not be able to return to work. The DON stated that a Resident's Advance Directive would be placed in a sleeve and would be the very first document in a resident's active medical record chart.

During a telephone interview, on 8/26/2019 at 3:35 PM, Licensed Practical Nurse (LPN) #1 confirmed that CNA #1 came to at the nurse's station about 10:30 PM (8/15/19), and reported that Resident #1 was not responding. LPN #1 stated that she immediately went to the Resident #1's room and CNA #1 followed her. LPN #1 stated that she assessed Resident #1 at that time, noting that the resident was not responding to verbal or tactile stimulus. LPN #1 stated that she told CNA #1 to start CPR, while she went to the nurse's station to check the resident's chart. LPN #1 stated that while she was at the station, she called the resident's daughter to tell her that the resident was not responding. LPN #1 stated that she went back to the resident's room and told CNA #1 that she couldn't find a code status, so they would have to consider the resident a full code. LPN #1 stated she took over the CPR. LPN #1 stated that she continued chest compressions, while CNA #1 was counting. LPN #1 stated that she only stopped performing CPR, when she heard Resident #1's ribs crack. LPN #1 stated that she called out to the nurse's station and told

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LPN #2 to bring the crash cart to Resident #1's room. LPN #1 stated that LPN #2 placed the crash cart at the foot of Resident #1's bed. LPN #1 stated, "I did not have an opportunity to use anything from the cart, I didn't even use the Ambu bag." LPN #1 stated that she was the only person in the room for some time. LPN #1 stated that the daughter walked into the room and said, "She's gone! She's gone!" LPN #1 stated that she took that statement to mean that the daughter did not want her to continue CPR. LPN #1 stated the Emergency Medical Technicians (EMTs) came in right behind the daughter. LPN #1 stated that after the EMTs checked Resident #1 for vital signs, and found none, they left. LPN #1 confirmed she was certified in CPR. Review of the Basic Life Support (CPR Certification) card for LPN #1, revealed a training date of 9/18/19, with the American Heart Association guidelines.

Review of a written statement, as part of the facility's investigation, signed by LPN #1, undated, revealed that she initiated CPR on Resident #1 and when the daughter came into the room, she stopped CPR after the daughter made the statement, "she's gone".

During an interview on 8/26/2018 at 3:55 PM, Licensed Practical Nurse (LPN) #2 stated that upon his arrival to the facility on 8/15/2019, for the 11:00 PM-7:00 AM shift, he passed Resident #1's room and noticed three (3) to four (4) staff members in the room. LPN #2 stated as he continued towards the nurse's station, LPN #1 called out to him and told him to bring her the crash cart. LPN #2 stated that while he was getting the crash cart, he also told LPN #3 to call 911, because he was unsure if anyone had called them yet. LPN #2 stated that he took the crash cart to the doorway of Resident #1's room. LPN

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M 500	Continued From page 12 #2 stated no one was doing chest compressions or CPR, so he left to assist another resident. LPN #2 also stated that LPN #1 never asked him to help her perform CPR. LPN #2 stated that he never heard anyone call a "Code Blue." During an interview on 8/26/2018 at 4:15 PM, Certified Nursing Assistant (CNA) #1 stated that she had been working the night of 8/15/2019, and was assigned to Resident #1. CNA #1 stated that she went to Resident #1's room while doing her end-of-shift rounds at about 10:30 PM, and noticed that Resident #1 was unresponsive. CNA #1 stated that she had been in the room twice, earlier in the evening, and the resident was fine. CNA #1 stated that when she touched Resident #1's arm, it still felt warm. CNA #1 stated when she saw that Resident #1 wasn't breathing, she immediately started doing chest compressions. CNA #1 stated that she only did about four (4) to five (5) pushes on Resident #1's chest, stopped, and went to go get a nurse. CNA#1 stated she reported that Resident #1 was gone/dead to LPN #1 at the nurse's station. CNA #1 stated LPN #1 got up from the nurse's station, got the vital sign machine, and went to Resident #1's room. CNA #1 stated that she accompanied LPN #1 back to Resident #1's room and LPN #1 instructed her to try to get Resident #1's vital signs and to start CPR, while she (LPN #1) went back to the nurse's station to check Resident #1's chart for her code status. CNA #1 stated when LPN #1 returned from the nurse's station, LPN #1 informed her that Resident #1 was a full code. CNA #1 stated LPN #1 then took over CPR. CNA #1 stated that she was present inside Resident #1's room, when LPN #2 pushed the crash cart from the doorway. CNA #1 stated that it was at this time that she left, because she realized that she still needed to finish her rounds, so she could	M 500		

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M 500	Continued From page 13	M 500		

clock out and go home. CNA #1 stated that she wasn't in the room when Resident #1's daughter arrived, but she did hear the daughter say, "She's gone." CNA #1 stated she finished rounds, and as she clocked out, she saw the EMTs arrive at the facility and go into Resident #1's room.

During a telephone interview, on 8/27/2019 at 11:10 AM, an Ambulance Service Representative (ASR) revealed that a report was filed, which stated the following: "Emergency Medical Technicians (EMTs) responded to a call from the facility that came in at 22:57. Caller stated that a resident is unresponsive, unconscious, and not breathing. EMTs arrived at the facility at 23:04. Nurse in charge (No Name) reported that the resident was okay 45 minutes earlier prior to EMTs arrival. Nurse (no name) reported that CPR had stopped per the daughter's request. Departed Facility at 23:20. Resident was: Dead on Arrival (DOA)." The ASR stated that this was all the information she could provide at this time.

During an interview, on 8/27/2019 at 11:41 AM, the facility's Provider Liaison for Admissions (PLA) revealed that she was the facility staff member who initiated the admission process. The PLA stated that she completed the admission packet with the daughter of Resident #1. The PLA stated that Resident #1's daughter, the Responsible Party (RP). The PLA stated that the Advanced Directives form was read out to loud to Resident #1's RP and the RP verbally stated that her mother, Resident #1, was to be a "Full Code". The PLA stated Resident #1's RP signed the Advance Directive form, and dated it 8/13/2019.

During an interview, on 8/27/2019 at 2:44 PM, Resident #1's RP/ Daughter stated that she signed the Admission Agreement on behalf of

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M 500	Continued From page 14 Resident #1, on 8/13/2019. The RP stated during this meeting she conveyed that the family wanted CPR to be performed. The RP stated that she was Emergency Contact Number #1 for Resident #1. The RP stated that on the night of 8/15/2019 at 10:44 PM, her sister, who was Emergency Contact Number #3, received a call and voicemail from the facility. The RP stated that the facility called again at 10:45 PM, and a nurse from the facility told her sister that their mother was unresponsive. The RP stated her sister notified her at 10:46 PM. The RP stated that on the night of 8/15/2019 at 11:04 PM, she arrived at the facility and as she approached her mom's room, she noticed that the door to her mom's room was wide open. The RP stated that she saw her mother from the doorway and her mother was turned slightly toward the left and the head of the bed was elevated. The RP stated that no one was in the room with her mother. The RP stated that she didn't see any staff until she turned and saw LPN #1 coming up the hall toward her. The RP stated that LPN #1 was shaking her head in an empathetic way, as to indicate to her that her mom had passed away. The RP stated that she remembered saying in an inquisitive manner to LPN #1, "She's gone? She's gone?" The RP stated that at no time did she see anyone doing CPR. The RP stated, "If I'd seen somebody doing CPR, I'd never told them to stop." The RP stated she followed LPN #1 into the room and her mom was already dressed. The RP stated her daughter, Resident #1's granddaughter, came into the room almost right behind her and asked, "What was going on?" The RP stated that the EMTs came in right behind her daughter and started talking to LPN #1. The RP stated that the EMTs checked for her mom's vital signs, stayed for a few minutes, and left.	M 500		

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M 500	Continued From page 15 During a telephone interview, on 8/28/2019 at 10:33 AM, Resident #1's Medical Doctor (MD) revealed that he had not been notified on the night of the incident that occurred on 8/15/2019, concerning Resident #1's death. The MD stated he was not on-call, so perhaps the call was forwarded to the on-call partner, but it was reported to him several days later. The MD replied "you're probably right", when questioned if CPR should continue once started. During a telephone interview, on 8/28/2019 at 2:19 PM, Licensed Practical Nurse (LPN) #3 confirmed that she was working on the 3:00 PM-11:00 PM shift on 8/15/2019. LPN #3 stated that she was sitting at the nurse's station documenting, when a CNA, walked up to LPN #1 and said that Resident #1 was dead. LPN #3 stated, "LPN #1 left the station, and returned approximately two (2) to three (3) minutes later, and told me that Resident #1 was dead." LPN #3 stated she asked LPN #1 if she had checked the resident's chart for her code status, and she said "No, I didn't". LPN #3 stated that she looked at Resident #1's chart and couldn't find a DNR or code status. LPN #3 stated that she told LPN #1 that it would have to be treated as a full code. LPN #3 stated she told LPN #1 to grab the crash cart, and that she would call the ambulance. LPN #3 stated that she also told LPN #1 that she would get the transfer paperwork filled out. LPN #3 stated that by the time she called 911, finished writing the paperwork, and she arrived at the room, the daughter, granddaughter, and the EMTs were all present in the room. LPN #3 stated that she gave the paperwork to the EMTs and then returned to the nurse's station. LPN #3 stated that at no time did she see or hear of anyone starting or stopping CPR. LPN #3 stated that she never heard anyone call a code over the	M 500		

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M 500	Continued From page 16	M 500		

intercom for someone to go to Resident #1's room. LPN #3 also stated that she was never told to call or ever heard a "Code Blue" called over the intercom that night. LPN #3 stated that when a "Code Blue" is called all staff are supposed to report to that location, because that means there is a full code in progress, due to a cardiac arrest or respiratory failure. LPN #3 stated that when CPR is initiated, it should always continue until the emergency team arrives or unless a doctor is present to say stop.

During an interview, on 8/28/2019 at 3:05 PM, the Director of Nursing (DON) confirmed LPN #1 did not continue CPR for Resident #1 once started, and suspended/terminated the LPN related to the investigation. The DON stated that an audit had been conducted on all of the resident charts in the facility to ensure that the Code Status in the computer matched the Code status on the chart and that the code status matched the care plans. The DON also stated an audit of residents that had expired in the facility over the last six (6) months was conducted to ensure the Code Status had been followed correctly. The DON stated that she suspended LPN #1 on 8/16/2019, pending the conclusion of the investigation and terminated the LPN on 8/27/19, for failure to continue CPR, once started, on a full code resident.

Review of Resident #1's face sheet, revealed the facility admitted the resident on 08/13/2019, with diagnoses to include Paroxysmal Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD), and Fracture of the shaft of Left Humerus.

Review of the 5-Day Minimum Data Set (MDS),

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M 500	Continued From page 17 with an Assessment Reference Date (ARD) of 8/15/2019, revealed that Resident #1 had not been assessed for a Brief Interview of Mental Status (BIMS) score, but had been identified as having modified independent decision-making skills. The facility submitted a Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: 1. After a conversation with Resident's #1's granddaughter on August 16, 2019, the Director of Nursing Services (DNS) initiated an investigation. 2. Licensed Practical Nurse (LPN) #1 was suspended pending an investigation on August 16, 2019, by the DNS for failure to continue CPR until Emergency Medical Services (EMS) arrived. 3. A 100 percent (%) audit of resident's charts was completed to verify all advanced directives and code status orders were in place on August 16, 2019, by the DNS. Results revealed every resident had correct code status in the computer. 4. A 100% audit of resident's charts for designated code status form on the front of the chart was conducted by the DNS on August 16, 2019. Results revealed two (2) residents did not have code status on the chart and code status was placed in the front of the chart; corrected immediately. 5. Eleven (11) Registered Nurses (RNs), 18 LPNs and one (1) Social Service Coordinator (SSC) were educated beginning August 16, 2019, and ending August 19, 2019, on CPR to include	M 500		

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M 500	Continued From page 18 correctly responding, performing CPR, and continuing CPR until EMS arrives and begins care or a physician in attendance and orders to cease CPR. 6. Eleven (11) RNs, 18 LPNs, and one (1) SSC were educated on the Advance Directive Policy by the DNS beginning on August 16, 2019, and ending on August 19, 2019. 7. Beginning August 16, 2019 and ending August 22, 2019, one (1) code drill was conducted daily on various shifts by the DNS and /or RN Unit Manager (UM) to include correctly responding to Code Blue being called, including all Licensed Nurses to be in room, performing CPR, and continuing CPR until EMS arrives and begins care, or a physician in attendance and orders are given to cease CPR. 8. The Nurse Consultant #1 and the Administrator conducted 100% audit of all Baseline Care Plans and Comprehensive Care Plan to include Code Status on August 27, 2019. The Baseline Care Plan audit revealed five (5) baseline care plans that did not reflect the code status in the chart. The Comprehensive Care Plan was correct for the five (5) residents. A care plan note was written in the medical records. The Comprehensive Care Plan audit revealed one (1) comprehensive care plan that did not reflect the code status in the chart and was updated to reflect code status. 9. The Director of Clinical Education (DCE) educated 11 LPNs, five (5) RNs and one (1) SSC on Baseline Care Plans to include correctly developing Baseline Care Plans on August 27, 2019.	M 500		

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M 500	Continued From page 19 10. The Mississippi State Board of Nursing was notified on August 27, 2019, related to the LPN #1's failure to provide CPR by professional standards and of her suspension. 11. LPN #1 was terminated on August 27, 2019, by the DNS for failure to continue CPR until EMS arrived for Resident #1. 12. The Quality Assurance Performance Improvement (QAPI) meeting was held on August 27, 2019 at 5:30 PM. Systemic changes and monitoring have been developed, presented and approved by Administrator, Director of Nursing Services, Nurse Consultant, Clinical Education Nurse, and Medical Director. Systemic changes include code status and baseline care plan review at the next day Daily Clinical Start Up meeting. Post CPR reviews will be conducted on any charts of residents who may have required CPR. Findings from CPR order audits and baseline care plan audits were discussed at the QAPI meeting. 13. The Administrator reported the Immediate Jeopardy to the Attorney General's office on August 27, 2019 at 8:30 PM. 14. RNs, LPNs, and CNAs will not be allowed to work until education has been completed on CPR and Baseline Care Plans. The facility alleges all corrective actions were completed on August 27, 2019, and removal of the immediate jeopardy on August 28, 2019. On 8/29/2019, The SA survey validated through staff interviews, record reviews, and in-service reviews that the facility had implemented the following measures to remove the Immediate	M 500		

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M 500	Continued From page 20 Jeopardy: 1. The SA verified the facility's investigation of Resident #1's death on 8/15/2019. Resident #1 was found unresponsive, without vital signs, with CPR initiated but not continuously provided per interviews, records reviews, and reviews of written statements from facility staff, and written reports to the SA. 2. The SA validated through record review, time card review, and interview with the DNS, that LPN #1 was suspended prior to her shift on 8/16/2019, and terminated on 8/27/2019. 3. The SA validated through document review and interview with the DNS that an audit was completed on 8/16/2019, of all resident charts to ensure that all Advance Directives, Code orders, and the Code Status on the chart was accurate according to the facility's computer and was easily accessible. 4. The SA validated through record review and interview with the DNS that the Administrator conducted a 100 % Audit of all resident's Base Line Care Plans to ensure the code status of all residents in the facility on 8/27/2019, were correct. 5. The SA validated through record reviews and through staff interviews of Registered Nurse (RN)s, Licensed Practical Nurse (LPN)s, Certified Nursing Assistants (CNAs), and Social Service Coordinator (SSC), that in-service training was conducted, starting on 8/16/2019, regarding responding correctly, providing CPR and continuing until EMS arrived or a physician gave an order to stop.	M 500		

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M 500	Continued From page 21 6. The SA validated through record reviews and through staff interviews of Registered Nurse (RN)s, Licensed Practical Nurse (LPN)s, Certified Nursing Assistants (CNAs), and Social Service Coordinator (SSC), that in-service training was conducted, starting on 8/16/2019, regarding Advance Directives. 7. The SA validated through record reviews and through staff interviews of Registered Nurse (RN)s, Licensed Practical Nurse (LPN)s, Certified Nursing Assistants (CNAs), that drills were conducted related to correctly responding to "Code Blue" and continuing until EMS arrived or a physician's order to discontinue. 8. The SA validated through interview and record review that the Nurse Consultant #1 and the Administrator conducted a 100% audit of all Baseline Care Plans and Comprehensive Care Plan to include Code Status on August 27, 2019, and corrected any negative findings. 9. The SA validated through interview and in-service record review that the Director of Clinical Education (DCE) educated 11 LPNs, five (5) RNs and one (1) SSC on Baseline Care Plans to include correctly developing Baseline Care Plans on August 27, 2019. 10. The SA validated through document review with the Mississippi Board of Nursing Investigator on 8/27/2019, that the office had received an online complaint on 8/27/2019, from the facility regarding LPN #1's failure to continue CPR to Resident #1 on 8/15/2019. 11. The SA validated through record review, time card review, and interview with the DNS, that LPN	M 500		

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M 500	Continued From page 22 #1 was suspended prior to her shift on 8/16/2019, and terminated on 8/27/2019, for failure to continue CPR on Resident #1. 12. The SA validated through record review of the Quality Assurance (QA) Committee sign it sheet, dated 8/16/2019, and interviews with the Administrator, the DNS, the Medical Director, and Registered Nurse (RN) #1/Unit Manager, that the facility initiated a QA Committee meeting on 8/16/2019, with the facility's Administrator, the DNS, Registered Nurse (RN) #1 Unit Manager, and Nursing Practitioner in attendance concerning the failure of LPN #1 to follow the Advance Directive for Code Status of Resident #1, Policy and Procedures pertaining to Code Status, CPR, and Advance Directives were reviewed. Systemic changes to resident's code status and Base Line Care plans were reviewed, and that follow-up will continue at the next day daily clinical start-up meeting. 13. The SA validated through record review and Administrator confirmation, that the Immediate Jeopardy status was reported to the Attorney General (AG)'s office on 8/27/2019. 14. The SA validated through interviews and schedule review, that the Nursing staff was not allowed to return to work until in-serviced. The SA validated that all corrective actions to remove the IJ were completed on 8/27/19, and the IJ removed on 8/28/19.	M 500		