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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

*****After Administrative review with CMS Regional Office (RO), this 2567 has been amended. The beginning date of the Immediate Jeopardy has been changed to 8/15/19. F 658 has been added at a S/S of "J". *****

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 until Emergency Medical Services (EMS) arrived or without a Do Not Resuscitate order. During the investigation, the SA found that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited regulatory deficiencies related to the complaint at F655, F658, and F678.

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, and standard of care, for Resident #1, who was a full code. 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, or a physician's order to discontinue the CPR. The facility also failed to develop an accurate Baseline Care Plan for Resident #1, regarding the Advance Directive for a full code.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/26/2019

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The failure to provide CPR and continue CPR, within the scope of professional standards of practice, via the American Heart Association's recommendations for Resident #1, placed this resident and other residents with a Full Code Advance Directive in a situation that was likely to cause serious injury, harm, impairment, or death. The noncompliance with the Advance Directive, resulted in Resident #1's death.

On 8/27/2019 at 4:10 PM, the SA notified the facility Administrator of the IJ and SQC.

The IJ and SQC existed at:
42 CFR(s): 483.24(a) (3)-Cardio-Pulmonary Resuscitation (CPR), (F678)

IJ existed at:
42 CFR(s):483.21(a) (1)-Base Line Care Plan, (F655) and,
42 CFR(s)483.21(b)(3)(i)-(F658) - Services Provided Meet Professional Standards.

The facility submitted an acceptable Removal Plan on 8/28/19, 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: 42 CFR(s): 483.24(a) (3)-Cardio-Pulmonary Resuscitation (CPR), (F678); 42 CFR(s):483.21(a) (1)-Base Line Care Plan, (F655); and 42 CFR(s) 483.21(b)(3) (i)-Services Provided Meet Professional Standards (F658) were lowered from a "J" to a scope and severity of a "D", while the facility

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F 000	Continued From page 2 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.	F 000		
F 655 SS=J	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		9/22/19

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F 655	Continued From page 3 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on Record Review, Facility Policy Review, Resident's Responsible Party (RP) Interview, and Staff Interview, the facility failed to accurately develop a Baseline Care Plan regarding an Advance Directive for a full code for one (1) of five (5) resident records reviewed, Resident #1. Resident #1's Baseline Care Plan summary listed Do Not Resuscitate (DNR) and the Advanced Directive was documented for a full code status (provide CPR for the Resident), signed by Resident #1's responsible party (RP). Resident #1 was found unresponsive and with no pulse at 10:30 PM on 8/15/2019, by Certified Nursing Assistant (CNA) #1. Licensed Practical Nurse (LPN) #1 was notified by CNA #1 that Resident #1 was unresponsive. CNA#1 states that she began CPR, but stopped. LPN #1 stated that she did not find the resident's code status in the medical record and began CPR, but stopped. The facility failed to develop an accurate Baseline Care Plan to alert staff to the resident's code status and failed to continuously provide CPR to	F 655	1. The resident has already been discharged from the center and the documentation system. 2. Each resident in the center has the potential to be affected by this deficient practice. 3. Nurse Consultant #1 and Administrator conducted 100% audit of Baseline Care Plan and Comprehensive Care Plan to include Code on August 27, 2019. Findings included five Baseline Care Plans were not correct and were corrected immediately and the Comprehensive Care Plan was correct. The Comprehensive Care Plan audit revealed one Comprehensive Care Plan did not reflect code status and was updated immediately. The Director of Clinical Education (DCE) educated Licensed Practical Nurses (LPN) and Registered Nurses (RN) on Baseline Care	

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F 655	Continued From page 4 Resident #1 until Emergency Medical Services (EMS) arrived or physician ordered CPR to cease. Resident #1 expired. The facility's failure to develop an accurate Baseline Care Plan for a full code status, as noted in the Advanced Directive, and signed by Resident #1's RP, resulted in staff failure to continue CPR. The noncompliance with the Full Code Resuscitation order of 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. The facility's Administrator was notified of the IJ on 8/27/19. The facility submitted an acceptable Removal Plan on 8/28/2019, 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 was removed on 8/28/2019. Therefore, the scope and severity for: 42 CFR(s):483.21(a) (1)-Base Line Care Plan, (F655) was lowered from a "J" to a scope and severity of a "D" level, 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 document titled, "Care Plans," dated June 2017, revealed that it is the policy of this facility that Care plans will be developed for all patients and residents based	F 655	Plans to include developing Base Line Care Plan beginning on August 27, 2019. Director of Clinical Education will provide training to new LPNs and RNs on Base Line Care Plans on hire during orientation. Director of Nursing Services and /or Unit Managers will review Baseline Care Plans for new admissions at the next day Daily Clinical start up meeting. 4. Director of Nursing Services and / or Unit Manager will report baseline Care Plan monitoring results to the centers Quality Assessment Performance Improvement Committee (QAPI)which is comprised of: Administrator, Medical Director, Director of Nursing Services and three other department heads month. This committee will review the results for additional monitoring, continued improvement and make recommendations as needed.	

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upon the Resident Assessment Instrument (RAI) manual guidelines. The facility policy states that Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change.

Review of the facility policy titled, "Advance Directives," dated November 1, 2016, revealed that the facility recognizes the dignity and value of each Resident's right to make health care decisions. The policy noted that the facility recognizes the right of each Resident to issue Advanced Directives regarding his or her health care; and that under an Advance Directive, a Resident may appoint an individual who is familiar with the Resident or whom the Resident trusts to make health care decisions on his or her behalf should the Resident lose capacity. The facility policy states that such healthcare decisions may include decisions regarding whether or not to receive or continue life support. The guidelines state that the facility will document in the Resident's medical record whether or not the Resident has executed an Advance Directive.

Review of Resident #1's medical records document titled, "Baseline Care Plan - V 3," with Resident #1's name and an admission date of 8/13/2019, revealed that the summary of the Baseline Care Plan documented: "Fall Risk DNR".

Review of Resident #1's medical records document titled, "Resuscitation Orders," dated 8/13/2019, 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

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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 Physician's Orders revealed no orders for a Do Not Resuscitate.

Review of a written report from Resident #1's family member, dated 8/22/19, revealed a complaint that facility staff started CPR on Resident #1 and didn't continue until EMS arrived. The report documented that when the family member 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 report documented the family member stated there was clearly no Code (CPR) performed on Resident #1.

Review of the facility's investigative report, dated 8/16/19, revealed there was an allegation from Resident #1's Responsible Party and her daughter that CPR was initiated and then 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 related to not continuing CPR on Resident #1.

During an interview, on 8/26/2019 at 10:45 AM, with the Director of Nursing (DON), it was revealed that she had been made aware of the

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incident that occurred on 8/15/2019, concerning Resident #1. The DON confirmed that she had reviewed Resident #1's Baseline Care Plan that had been developed upon admission, and it in the summary it did indeed state, "Fall Risk/DNR." The DON stated, "The Advance Directive that was signed said Resident #1 was a full code, so I don't know why there is a DNR on the summary, and I don't know who would have put it on there either." The DON confirmed the care plan should have reflected the Advanced Directive for CPR for Resident #1.

During an interview, on 8/27/2019 at 11:41 AM, the facility's Provider Liaison for Admissions (PLA) revealed that she completed the admission packet with the daughter and Responsible Party (RP) of Resident #1. The PLA stated that the Advanced Directives form was read out to loud to Resident #1's RP. The PLA stated that Resident #1's 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 for 8/13/2019.

During an interview, on 8/27/2019 at 2:44 PM, Resident #1's RP revealed that she was the person who signed the Admission Agreement on behalf of Resident #1 on 8/13/2019. The RP stated that during this meeting she conveyed that the family wanted CPR to be performed.

Further interview with the DON on 8/28/19 at 3:05 PM, revealed LPN #1 was responsible for not continuing CPR on Resident #1 until EMS arrived or a physician's order to discontinue CPR, and had been terminated on 8/27/19.

Review of Resident #1's face sheet, revealed the

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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), 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

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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 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

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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.

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

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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 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

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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.

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

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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 #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.

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F 655	Continued From page 14 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.	F 655		
F 658 SS=J	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on Record Review, Facility Policy Review, Responsible Party (RP) Interview, and Staff Interview, the facility failed to continuously deliver care within the scope of professional standards of practice for Cardio-Pulmonary Resuscitation (CPR) for one (1) of five (5) resident's reviewed, Resident #1. Resident #1 was found unresponsive and with no pulse at 10:30 PM, on 8/15/2019, by Certified Nursing Assistant (CNA) #1. Licensed Practical Nurse (LPN) #1 was notified that Resident #1 was unresponsive. CNA#1 stated that she began CPR, but stopped. LPN #1 stated that she began CPR, but did not continue until Emergency Medical Services (EMS) arrived. Resident #1's Responsible Party (RP) and the EMS staff reported that CPR was not in process when they arrived to the resident's room. The failure to continuously deliver care within the	F 658	1. Licensed Practical Nurse (LPN) #1 was suspended pending investigation on August 16, 2019 and terminated on August 27, 2019. Mississippi Board of Nursing was notified on August 27, 2019, related to LPN #1's failure to provide CPR by professional standards and of LPN #1 suspension. 2. The fifty nine resident that has a Full Code Status has the potential to be affected by this deficient practice. 3. Director of Nursing Services (DNS) completed 100% audit of residents' charts on August 16, 2019, to verify all advanced directives and code status order were in place and accurate based upon the MD order. Findings of audit revealed every resident had the correct code status in the physicians order in the computer.	9/22/19

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F 658	Continued From page 15 scope of professional standards of practice for CPR, until the arrival of the EMS, 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 with the likelihood 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. 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, 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 Action Plan on 8/29/2019, and determined the IJ was removed on 8/28/2019. Therefore, the scope and severity for: 42 CFR(s): 483.24(b) (3) (i)-Services Provided Meet Professional Standards, (F658) was lowered from "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systematic 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	F 658	Director of Nursing Services (DNS)completed 100% audit of residents charts for designated Resuscitation Order form in front of chart on August 16, 2019. Findings of audit revealed two residents did not have the Resuscitation Order form in the front of the chart, this was corrected immediately on August 16, 2019. Beginning August 16, 2019 and ending August 19, 2019, DNS educated Registered Nurses (RN), Licensed Practical Nurses (LPN) and Social Services Coordinator (SSC) on centers Cardio Pulmonary Resuscitation Policy (CPR) to include correctly responding, performing CPR and continuing CPR until EMS arrives and begins care or 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 Advanced Directive Policy. Director of Clinical Educations will train LPNs and RNs on Cardio Pulmonary Resuscitation Policy to include responding, performing CPR and continuing CPR until EMS arrives and begins care or a physician in attendance and gives order to cease CPR and Advance Directive Policy on hire during orientation. 4. Director of Nursing Services and / or Administrator will conduct post CPR	

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F 658	Continued From page 16 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 and any related physician order such as code status, or in the absence of advance directives or a Do Not Resuscitate (DNR) order. The facility policy's procedural guidelines noted that CPR will be initiated when cardiac arrest (CA) occurs for residents who have requested CPR in their Advance Directives. Review of the facility policy titled, "Advance Directives," dated November 1, 2016, revealed that it is the policy of this facility that the facility recognizes the dignity and value of each Resident's right to make health care decisions and to be fully informed of his or her health status. The facility policy noted the facility recognized the right of each Resident to issue Advanced Directives regarding his or her health care. The facility policy noted Advanced Directives that comply with state law and that are consistent with the level of care the facility is licensed to provide, will be honored. The policy noted 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 policy also noted that under an Advance Directive, a Resident may appoint an individual who is familiar with the Resident, or whom the Resident trusts, to make health care decisions on his or her behalf should the Resident lose capacity. The facility policy	F 658	reviews on any charts o residents who my have required CPR x three months. Beginning August 16, 2019 and ending August 22, 2019, once CPR code drill was conducted by Director of Nursing Services, Unit Manager and / or Registered Nurse daily on various shifts to include correctly responding to Code Blue being called, all Licensed Nurses to be in the 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 ending September 15, 2019, Director of Nursing Services, Unit Manager or Registered Nurse conducted CPR drills. Baseline Care Plans for new admissions will be reviewed daily at the next day Daily Clinical Start Up Meeting. Administrator and / or Director of Nursing Services will report finding to centers Quality Assessment Performance Improvement (QAPI) Committee which is comprised of: Administrator, Director of Nursing Services, Medical Director 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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states that such healthcare decisions may include decisions regarding whether or not to receive or continue life support. The procedural guidelines also noted that the facility will provide education and training to its staff regarding policies and procedures related to Advance Directives.

Review of Resident #1's medical records document titled, "Resuscitation Orders," dated 8/13/2019, 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 medical records revealed a "Progress Note", dated 08/15/2019, which noted that Licensed Practical Nurse (LPN) #1 entered a General Note at 11:34 PM. The note read documented that a CNA stated Resident #1 was put to bed around 7:30 PM. At approximately 8:30 PM, LPN #1 went to give the resident medication. At approximately 8:55 PM, CNA rounded and stated Resident was fine. CNA rounded at approximately 10:30 PM, came to the nurses' station, and stated the resident was not responding. LPN #1 electronically documented that a Code was called and CPR performed. LPN #1 documented that vital signs were not registering and the Coroner was called by ambulance services.

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

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occurred on 8/15/2019, concerning Resident #1's code status. 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 Status, and Base Line Care Plans. The DON stated that until in-serviced, the Nursing Staff would not be able to return to work.

During a telephone interview, on 8/26/2019 at 3:35 PM, Licensed Practical Nurse (LPN) #1 confirmed that she was notified by CNA #1, about 10:30 PM, 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 called the telephone number on the chart, but it was not the daughter, who was Resident #1's emergency contact. LPN #1 stated that she went back to the resident's room and told CNA #1 that she couldn't find a code status, and so she (LPN #1) would take 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 LPN #2 to bring the crash cart to Resident #1's room. LPN #1 stated that LPN #2

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placed the crash cart at the foot of the Resident #1's bed, when he brought it into the room. 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.

During an interview on 8/26/2018 at 3:55 PM, Licensed Practical Nurse (LPN) #2 revealed that he arrived on 8/15/2019, for the 11:00 PM to 7:00 shift, he passed Resident #1's room and noticed three (3) to four (4) staff members in the room. LPN #2 stated that 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 #2 stated no one was doing chest compressions or CPR, so he left to go assist with another resident who had fallen. 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, CNA #1 revealed that she had been working the night of 8/15/2019, and was assigned to Resident #1. CNA #1 stated that she went into Resident #1's room while doing her end-of-shift rounds at

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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 just fine. CNA #1 stated that when she touched Resident #1's arm, she still felt warm. CNA #1 stated when she saw that Resident #1 wasn't breathing, she immediately started doing chest compressions and only did about four (4) to five (5) pushes on Resident #1's chest, then stopped to get a nurse. CNA #1 stated she reported that Resident #1 was gone 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 she accompanied LPN #1 back to Resident #1's room, where 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 states that LPN #1 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 that she could 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 that after her rounds, she clocked out. CNA #1 stated that as she was clocking out, she saw the EMTs arrive 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 a report was filed with the billing

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department of the facility's Ambulance Service. The ASR stated that in the report, it noted the following: "Emergency Medical Technicians (EMTs) responded to a call from the facility that came in at 22:57 (10:57 PM). Caller stated that a resident is unresponsive, unconscious, and not breathing. EMTs arrived at the facility at 23:04 (11:04 PM). 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 (11:20 PM). Resident was: Dead on Arrival (DOA)." The ASR stated that this was all the information she could provide me at this time.

During an interview, on 8/27/2019 at 2:44 PM, Resident #1's Responsible Party (RP)/ Daughter revealed that she was the person who signed the Admission Agreement on behalf of 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 Contact #1 for Resident #1. The RP stated that on the night of 8/15/2019 at 10:44 PM, her sister, who was Contact #3, received a call from the facility. The RP stated that her sister didn't answer this call, but LPN #1 did leave a voice mail. The RP stated 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 that her sister called her and while she was on her way to the facility, she contacted her daughter. The RP stated that on the night of 8/15/2019 at 11:04 PM, she arrived at the facility. The RP stated that 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. The RP stated that her mother was

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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 remembers saying in an inquisitive manner to LPN #1, "She's gone? She's gone?" The RP stated that LPN #1 called out for someone to get her a chair, and then LPN #1 proceeded into the room. The RP stated that at no time did she see anyone doing CPR. The RP stated, "If I'd a seen somebody doing CPR, I'd a never told them to stop." The RP stated she followed LPN #1 into the room. The RP stated that 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, asking them what was going on. The RP stated that the EMTs checked for her mom's vital signs, stayed for a few minutes, and left.

During a telephone interview, on 8/28/2019 at 10:33 AM, Resident #1's Medical Doctor (MD) revealed if CPR was initiated, then it should continue.

During a telephone interview, on 8/28/2019 at 2:19 PM, LPN #3 confirmed that she was sitting at the nurse's station documenting before the shift changed, when a CNA, whose name she doesn't know, walked up to LPN #1 and said that Resident #1 was dead. LPN #3 stated, "LPN#1 left the station, and returned approximately 2-3 minutes later, and told me that Resident #1 was

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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. 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 for someone to go to Resident #1's room over the intercom. LPN #3 stated she was never told to call, nor did she ever hear, a "Code Blue" called over the intercom that night. LPN #3 stated 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 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) revealed that she suspended LPN #1 on 8/16/2019, pending the conclusion of the investigation. The DON stated that she terminated LPN #1 on 8/27/2019, for not continuing CPR once initiated.

Review of Resident #1's face sheet, revealed the

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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 Minimum Data Set (MDS), 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

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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 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

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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.

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

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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 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

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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.

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

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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 #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.

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F 658	Continued From page 30 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.	F 658		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: 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.	F 678	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 pendig 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	9/22/19

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F 678	Continued From page 31 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. 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	F 678	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 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.	

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F 678	Continued From page 32 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 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	F 678	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 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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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 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.

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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 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,

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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 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

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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 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.

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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 #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.

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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 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

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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 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

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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.

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

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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 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,

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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), 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

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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 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

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/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.

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

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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 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

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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.

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

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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 #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

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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.