

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

PRINTED: 07/01/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2020
NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 530 HALL ST WIGGINS, MS 39577		
(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 The State Agency (SA) initially conducted an annual recertification survey at the facility from 11/25/2019 to 11/27/2019. After Administrative and Quality Assurance (QA) review, it was determined more information and investigation was required. The survey was extended from 1/28/2020 to 1/31/2020 due to an Immediate Jeopardy related to the facility's failure to honor a resident's right and Advanced Directive for a Do Not Resuscitate (DNR) code status. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA identified Immediate Jeopardy and Substandard Quality of Care existed at 42 CFR(s):483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR) (F678) and 42 CFR(s):483.25 Quality of Care (F684). The SA identified Immediate Jeopardy at 42 CFR(s):483.10(c)(6)(8)(g)(12)(i)-(v) Advance Directive, Residents Rights (F578); 42 CFR(s):483.21(b)(1) Comprehensive Care Plan (F656); and 42 CRR(s):483.75 (g)(2) Quality Assessment and Assurance (F867). The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) began, on 10/6/2019, when the facility's staff initiated Cardio-Pulmonary Resuscitation (CPR) on Resident #74, who was found unresponsive, pulseless and not breathing, and continued to provide CPR for five (5) minutes until the Emergency Medical Services (EMS) arrived and reviewed Resident #74's medical record and found Resident #74 was a Do Not Resuscitate (DNR) resident. The facility's staff failed to identify Resident #74 as a DNR code status resident prior	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/12/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 to initiating CPR. The facility's failure to identify and honor Resident #74's rights and Advance Directive for DNR, placed Resident #74 and other DNR residents in a situation that was likely to cause serious injury, harm, impairment, or death. The facility also failed to monitor, review and evaluate their Quality Assessment and Assurance (QAA) plan to identify and document the resident's Advance Directive choice for code status. During the initial recertification survey on 11/25/2019 to 11/27/2019, the State Agency (SA) identified the facility's failure to honor Resident #74's Do No Resuscitate (DNR) code status, on 10/6/2019. During the extended survey, 1/28/2020 to 1/31/2020, the SA identified inaccurate code status documented for Resident #31 and #64. This concern was identified for three (3) of 78 (facility's census at time the SA's re-entrance) resident code status reviewed. On 1/29/2020 at 12:05 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an Acceptable Removal Plan on 1/30/2020, in which the facility alleged all corrective actions were completed on 1/30/2020, and the IJ was removed on 1/30/20. The SA validated the facility's Removal Plan on 1/31/2020 and determined the IJ was removed on 1/30/2020, prior to exit. Therefore the scope and severity for 42 CFR(s):483.10(c)(6)(8)(g)(12)(i)(v) Advance Directive, Residents Rights (F578); 42 CFR(s):483.21(b)(1) Comprehensive Care Plan (F656); 42 CFR(s):483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR) (F678); 42 CFR(s):483.25 Quality of Care (F684) and 42 CRR(s):483.75 (g)(2) Quality Assessment and	F 000			

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F 000	Continued From page 2 Assurance (F867) were lowered from a "J" to a scope and severity of a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The SA also cited deficiencies at F550 and F697, during the survey. The facility held a license for 99 beds and had a census of 78 at the time of the survey.	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		2/28/20	

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F 550	Continued From page 3 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to assist three (3) of six (6) residents, who attended the Resident Group Interview meeting, on 11/25/2019, to participate in the Gubernatorial election on 11/6/2019. The residents who voiced their concern regarding their voting rights were Resident #20, Resident #44 and Resident #54. Finding include: Review of the facility's policy titled, "Residents Right To Vote", dated 9/2018, revealed that prior to an election, the social worker, social service designee, or assigned staff member should identify the residents who choose to vote, and identify the residents who need to register. In an interview, on 11/25/2019 at 3:00 PM, during the Resident Group Interview meeting, three (3) of the six (6) residents, Resident # 20, Resident	F 550	1. Resident #20, #44 and #54 were made aware of their right to vote and the facilities plan to ensure they can exercise their right to vote on 12/3/2019 by the Social Services Director. 2. All residents who wish to vote have the potential to be affected. 3. A resident council meeting was held with the Social Services Director on 12/3/2019 to discuss the facilities policy and procedure to accommodate residents who wish to exercise their right to vote during an election. The Social Services Director will establish and maintain a list of all residents who have expressed the desire to vote in upcoming elections beginning 12/3/2019. Each resident will be approached prior to the election and it will be documented in the medical record if		

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F 550	Continued From page 4 #44, and Resident #54 stated they did not get to vote in the general Gubernatorial election on 11/6/2019. They expressed the desire to vote. In an interview, on 11/25/2019 at 3:25 PM, the Social Worker revealed she had a list of the three (3) residents who voted, and the others did not vote because they did not say they wanted to. In an interview, on 1/29/2020 at 11:15 AM, the Administrator revealed before the survey in November, the residents were asked in Resident Council if they wanted to vote. Since the survey in November, the facility now asks the residents on admission if they would like to vote. Since November 2019, residents with a Brief Interview for Mental Status (BIMS) of 13 or higher are asked on admission and every month in resident council meetings if they would like to vote. The Administrator did state before the survey in November 2019, they did not check with all residents with a BIMS of 13 or higher about voting, but now they do. The administrator confirmed there have been no other elections since the November 2019 Governor's election. The Administrator stated the facility does provide transportation for the residents who want to go vote, and if the resident wants to vote by absentee, or wanted to register we assist them with that also. The Administrator stated if the resident is not registered to vote, the resident will be assisted to register on admission and when the elections come up. The Administrator stated the Social Services staff are responsible to oversee the resident's voting rights. The Administrator confirmed the residents who do not attend the council meetings will be addressed individually about their voting rights. The Administrator stated when an election comes up it	F 550	they wish to exercise their right to vote in any upcoming elections effective 12/3/2019. The Social Services Director will post in writing a notice of upcoming elections in a highly visible area effective 12/3/2019. The Social Services Director will also post upcoming elections on the information monitors effective 12/3/2019. 4. The Social Services Director will report monthly beginning 12/3/2019 to the Quality Assurance committee and Quality Assurance Performance Improvement program committee on the residents right to vote and any updates to the list of residents that wish to exercise their right to vote. This will be monitored and reported to each committee until 12/01/2020 for review and recommendation.		

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F 550	Continued From page 5 will be posted for the residents to see, and discussed in the resident council meetings. The Administrator stated, this may not cause harm to a resident, but it does violate their right to vote. Review of the Resident Council minutes from July 2019 to November 2019 revealed there was no documentation the residents had been offered the opportunity to vote. Review of the Quarterly Minimum Data Sets (MDS), dated 10/11/2019, revealed Resident #44 had a BIMS score of 15, which indicated no cognitive impairment. Review of the most recent Quarterly MDS, dated 10/17/2019, revealed Resident #54 had BIMS score of 15, which indicated no cognitive impairment. Review of the Annual MDS, dated 11/26/2019, revealed Resident #20 had BIMS score of 15, which indicated no cognitive impairment.	F 550			
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		2/28/20	

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F 578	Continued From page 6 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and interviews, the facility failed to comply with Resident #74's right to refuse or accept treatment regarding her wishes for no Cardiopulmonary Resuscitation (CPR) in the event if her heart stops beating or she stops breathing, no other medical treatment would be started or continued. Resident #74 had an elective Advanced Directive for a Do Not Resuscitate (DNR) code status and a Physician's Order for a DNR, dated 5/9/2018.	F 578	1. On 10/6/2019 at 7:28 PM, resident #74 was found unresponsive and Cardiopulmonary Resuscitation was initiated by the Nurse. The Nurse failed to check the resident's code status and initiated Cardiopulmonary Resuscitation. Cardiopulmonary Resuscitation was continued on Resident #74 by the Nurse for five minutes until emergency services arrived and notified the Nurse of a do not		

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F 578	Continued From page 7 On 10/6/2019, the facility staff did not verify Resident #74's code status, before initiating Cardiopulmonary Resuscitation (CPR) when staff discovered the resident unresponsive with no evidence of a pulse or respirations. An Immediate Jeopardy (IJ) was determined to exist, on 10/6/2019 at 7:28 PM, when facility staff found Resident #74 unresponsive, without a pulse or respirations. The facility's staff initiated Cardio-Pulmonary Resuscitation (CPR) on Resident #74 and continued to provide CPR for five (5) minutes until the Emergency Medical Services (EMS) was notified and the local Fire Department arrived and reviewed Resident #74's medical record and found Resident #74 was a Do Not Resuscitate (DNR) resident. The CPR was stopped, and Resident #74 was pronounced deceased at 7:42 PM. Resident #74 was never revived during the CPR. The facility's failure to identify Resident #74 as a DNR resident prior to initiating CPR resulted in the resident's decision for a DNR status not being honored or followed by the facility. The facility's failure to identify Resident #74's rights and Advance Directive for a DNR, placed Resident #74 and other DNR residents in a situation that was likely to cause serious injury, harm, impairment, or death. On 1/29/2020 at 12:05 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an Acceptable Immediate Jeopardy Removal Plan on 1/30/2020, in which the facility alleged all corrective actions were completed on 1/29/2020, and the IJ was removed on 1/30/20.	F 578	resuscitate code status. Cardiopulmonary Resuscitation was discontinued on resident #74 at this time. Resident #74 had a physician order dated 5/9/2018 for a do not resuscitate code status and an Advance Directive dated for 5/9/2018 stating do not resuscitate. Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status was not in the Electronic Health Record, according to their wishes which could have caused harm for Residents #31 and #64. The Nurse was in-serviced on 10/8/2019 by the Director of Nursing. The Nurse Supervisor was separated of her job duties on 1/31/2020 as a disciplinary action. 2. All residents have the potential to be affected. 3. The Director of Nursing conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. On November 27th, 2019, the Care Plan Nurse conducted in services for all licensed nurses from 7:30 AM to 5:30 PM on initiating Cardiopulmonary Resuscitation and how to identify resident code status. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the right to choose code status and		

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F 578	Continued From page 8 The SA validated the facility's Removal Plan on 1/31/2020 and determined the IJ was removed on 1/30/2020, prior to exit. Findings include: Review of the facility's policy titled, "Advance Directives Policy", dated 11/2018, revealed the Advance Directive definition was a written instruction, such as a living will or durable power of attorney for health care, recognized by State law, relating to the provisions of health care when the individual was incapacitated. The Do Not Resuscitate (DNR) definition indicated that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life sustaining treatments or methods are to be used. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Further review of the policy revealed information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. Review of the facility's policy titled, "Resident Rights", dated 01/2019, revealed: The facility will protect and promote the rights of the resident. A resident has the right to exercise his or her rights as a resident of the facility. Review of the facility's policy titled, "Cardiopulmonary Resuscitation (CPR) Policy", dated 10/2018, revealed, it is the policy of this facility to adhere to resident's rights to formulate	F 578	Cardiopulmonary Resuscitation policies. On January 29th and 30th, 2020, the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedures related to communication of code status with all licensed nurses. On January 29th, 2020 beginning at 1:30 PM and ending on January 30th, 2020 3:00 PM all staff was in serviced by the Administrator and the Director of Nursing to include assistance with code and code location in the event of an emergency. The Director of Nursing conducted an in service on January 31st, 2020 at 1:24 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. The Director of Nursing conducted an in service on February 28th, 2020 at 1:24 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. 4. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. A plan of action was implemented on 12/13/2019 to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status.		

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F 578	Continued From page 9 advance directives, and the facility will implement guidelines regarding cardiopulmonary Resuscitation (CPR). If a resident experiences a cardiac arrest, the facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and in accordance with the resident's advance directive. Review of Resident #74's Progress Notes-Nursing Notes, dated 10/6/2019 at 9:18 PM, revealed a note at 7:28 PM stated the Charge Nurse, Medication (Med) cart nurse, Registered Nurse (RN) and three (3) Certified Nursing Assistants (CNAs) entered the room and Resident #74 was found unresponsive and no pulse. The resident was assisted to the floor via a sheet and Cardiopulmonary Resuscitation (CPR) was initiated per the American Heart Association protocol and 911 was called at 7:30 PM. The Fire Department arrived at 7:35 PM and the resident's chart was reviewed to discover the resident was a DNR. CPR was ceased at that time. Resident was pronounced at 7:42 PM. The Coroner arrived at 8:11 PM, and the resident's body was released to the funeral home at 8:32 PM. The Nurses Notes revealed CPR was performed for five (5) minutes, prior to the fire department's arrival. An interview, on 1/30/2020 at 3:24 PM, with Registered Nurse (RN) #1/Supervisor, revealed she confirmed she did not ask anybody to get the chart until the Fire Department personnel asked for it. RN #1 said they received a call from the lab reporting a critically high Potassium level. RN #1 stated the Medical Doctor (MD) instructed them to send Resident #74 to the Emergency Room (ER) for evaluation and treatment. Resident #74 was left alone in the room with the Certified Nursing Assistant (CNA). RN #1 could not	F 578	The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow facility policies or procedures related to the code status of each resident. A plan of action was implemented on 1/29/2020 to ensure that all licensed nurses were in serviced on the Advance Directive Protocol for Determining Code Status. All resident charts were audited on 1/29/2020 to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit on 1/29/2020 and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies were reviewed on 1/29/2020 and no revisions were required. The Quality Assurance Committee met on January 31st, 2020 to discuss the implementation of the facilities action plan to prevent any future adverse events. The facility will audit each residents code status daily for five days beginning February 3rd 2020, weekly for four weeks, then monthly for six months with a 100% success rate ending September 31st, 2020. The audit will include the residents name, electronic health record, condition alert, face sheet, care plan and written physicians' orders. The audits will be documented and completed with a signature from two Administrative Nurses beginning 2/3/2020, presented to the Quality Assurance Nurse for review and presented to the monthly Quality		

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F 578	Continued From page 10 remember who the CNA was. RN #1 stated the CNA came to the door saying, "I don't think she's breathing". RN #1 stated RN #5 and Licensed Practical Nurse (LPN) #2 initiated CPR. RN #1 said she entered the room and instructed another CNA to call 911. RN #1 said the next thing she knew was when she looked up and the Fire Department was at the facility, and that was when Resident #74's DNR status was identified. RN #1 said she did not know what happened, it happened so quick. RN #1 did say she had been in-serviced several times on where to look for a resident's code status to ensure it was identified and provided per the resident's request. Review of the Progress Notes-Nurses Notes, dated 10/6/2019 at 7:17 PM, revealed a call was received from (Name of Hospital) lab reporting a critically high Potassium level of 8.7. Relayed to (Name of MD) who instructed to send resident to (Name of Hospital) to be evaluated and treated. (Names of Contact Persons) were notified and verbalized understanding. An interview, on 1/30/2020 at 3:30 PM, revealed RN #5/Charge Nurse confirmed she did not ask anybody to get the chart to review Resident #74's code status. RN #5 said she did not ask anybody to get the chart because she thought RN #1/Supervisor had checked the chart for the code status. RN #5 said she was called into the room by a CNA. RN #5 said she provided chest compressions and LPN #2 provided mouth to mouth breathing. During an interview, on 1/30/2020 at 3:59 PM, LPN #2 revealed she assisted RN #5 with resuscitating Resident #74. LPN #2 confirmed she did not ask anybody to get the chart. LPN #2	F 578	Assurance Committee and Quality Assurance Performance Improvement Program Committee for review and recommendation. If 100% accuracy is not achieved an immediate action plan will be developed and implemented. The Director of Nursing will conduct a mock code drill to include policy and procedure related to advance directives and code status with individual nurses randomly for six months beginning January 1st, 2020 and ending June 31st, 2020. The director of Nursing will report findings to the Quality Assurance and Quality Assurance Performance Improvement program committee for review and recommendation.		

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F 578	Continued From page 11 stated she has been trained where the code status was located in the chart. LPN #2 also stated she thought the supervisor had checked the chart for Resident #74's code status. Review of the facility's Advanced Care Planning form revealed Resident #74's printed name and her daughter's printed and signed name, dated 5/9/2018, for an elected DNR code status. Resident #74's Admission Record revealed the resident's daughters were the first and second contact persons. The resident's Advanced Directive was a Do Not Resuscitate. Review of Resident #74's Physician's Orders revealed an order, dated 5/9/2018, for a DNR code status. During an interview, on 11/26/2019 at 4:44 PM, Firefighter #1, revealed on 10/6/2019, upon responding to the 911 call, the Chief obtained Resident #74's chart and discovered that Resident #74 was a DNR code status. Firefighter #1 stated that CPR was ceased at that time. An interview, on 1/29/2020 at 12:22 PM, an interview with the Assistant Director of Nurses (ADON) revealed she was responsible for checking the residents code status and making sure there's a written order that is in the electronic record and on the Medication Administration Record (MAR). The ADON stated Resident #74's DNR order was in the chart Physician's Orders, and on the MAR. Resident #74's DNR code status was not honored due to the nurse's failure to check the Physician's Orders and MAR. During an interview, on 11/26/2019 at 5:52 PM, the Director of Nursing (DON) confirmed	F 578			

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F 578	Continued From page 12 Resident #74's code status was a Do Not Resuscitate (DNR), and when the resident was found unresponsive, on 10/6/2019, the Charge Nurse initiated CPR. The DON stated after they found out the resident was a DNR, CPR was stopped. As a result, Resident #74's DNR code status choice was not honored. During an interview, on 11/26/2019 at 4:46 PM, the Deputy Coroner stated the fire department had already pronounced the resident by the time he arrived. The Deputy Coroner said he was told the staff had performed CPR and the resident was never revived. An interview with the Medical Director, on 1/29/2020 at 11:53 AM, revealed he was made aware of the staff initiating CPR after the EMS staff left the building. The Medical Director stated he was told the staff found the resident unresponsive and initiated CPR until the Fire Chief pulled the resident's chart and noted she was a DNR, and the Fire Chief stopped the CPR at that moment. The Medical Director stated the resident could have had a negative outcome of surviving with broken ribs or being placed on a ventilator. Review of the Admission Record revealed Resident #74 was admitted by the facility, on 05/09/2018, with the included diagnoses Cardiomyopathy, Heart Failure, Cardiomegaly, Tachycardia, Pulmonary Disease and Chronic Atrial Fibrillation. Review of Resident #74's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/23/2019, revealed Resident #74 had a Brief Interview for Mental Status (BIMS)	F 578			

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F 578	Continued From page 13 score of 14, which indicated the resident was cognitively intact. This is the facility's accepted Immediate Jeopardy Removal Plan: Summary of events: The State Agency notified Azalea Gardens Nursing Center on January 29th, 2020 at 12:05 P.M. of the immediate jeopardy and substandard quality of care for Residents #74, #31, and #64. The Facility failed to honor Resident #74's advance directive for a do not resuscitate (DNR) code status, failed to honor the Resident's Rights for Advance Directive, failed to follow the care plan for a DNR code status and failed to prevent a potential negative outcome by initiating Cardiopulmonary Resuscitation (CPR). Resident #74 was found pulseless on October 6th, 2019 at 7:28 PM by RN #1 who initiated Cardiopulmonary Resuscitation (CPR) for a total of five minutes. CPR was discontinued when emergency services arrived and notified RN #1 of Resident#74's DNR code status. RN #1 failed to follow the policy and procedures in place to identify Resident #74's code status. The State Agency notified the facility on January 28th, 2020 at 3:30 PM that Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status was not in the Electronic Health Record, according to their wishes which could have likely caused harm for Residents #31 and #64. The facility failed to follow policy and procedure to identify the correct code status for Residents #74, #31, and #64. Facility action plan:	F 578			

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F 578	Continued From page 14 1. The Director of Nursing (DON) conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with Registered Nurse (RN) #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. On November 27th, 2019 Care Plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. On January 29th and 30th, 2020 the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. On November 27, 2019 the Assistant Director of Nursing (ADON) reviewed all code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies. The findings were 55 DNR and 22 full code status. 6. On January 29th, 2020 at 12:05PM, the State Agency identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. Care Plan Nurse found that Resident #64's order had been discontinued by Licensed Practical Nurse	F 578			

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F 578	Continued From page 15 (LPN) #1 and the order was reentered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status. 8. The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A	F 578			

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F 578	Continued From page 16 plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. No staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member. The facility alleges the immediate jeopardy was removed on January 30, 2020. On 1/31/2020, the State Agency (SA) validated the facility's Removal Plan by staff interviews, record reviews, review of in-service sign-in sheets, and review of documents across all disciplines. The SA verified the facility had implemented the following measures to remove the IJ: 1. The SA validated through record review of the sign-in sheets and interview with the Director of Nursing (DON) that the facility conducted an in service on October 8th, 2019 at 2:30 PM to	F 578			

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F 578	Continued From page 17 include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with RN #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. The SA validated through record review of the in-service sign-in sheets and interview with the Care Plan Nurse that on November 27th, 2019 Care plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. The SA validated through record review of the sign-in sheets and interview with the DON that the facility conducted an in-service on December 24th, 2019 at 1:30 PM, by the Director of Nursing, to all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. The SA validated through record review of the in-service sign-in sheets and interview with the facility owner that on January 29th and 30th, 2020, the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. The SA validated by interview of the ADON that on November 27, 2019 the ADON reviewed all code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies. The findings were 55 DNR and 22 full code status. 6. The SA validated by record review and staff interviews, on January 29th, 2020 at 12:05 PM,	F 578			

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F 578	Continued From page 18 the SA identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. The Care Plan Nurse found that Resident #64's order had been discontinued by LPN #1 and the order was re-entered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by the Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The SA validated by interviews the Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status. 8. The SA validated through interviews with the Facility Administrator and the DON the Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met	F 578			

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F 578	Continued From page 19 was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. The SA validated through interviews with the Administrator and the DON that no staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member. The SA validated that all corrective actions to remove the IJ had been completed as of 1/30/2020, and the IJ removed on 1/31/2020, prior to exit.	F 578			

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F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		2/28/20	

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F 656	Continued From page 21 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to ensure Resident #74's Care Plan was implemented for a Do Not Resuscitate (DNR) code status, and to develop/implement Resident #22's Care Plan for pain medication administration as needed during wound care. These concerns were identified for two (2) of 30 care plans reviewed. Resident #74 had a Care Plan initiated and revised, on 7/25/2019, for a DNR code status. The SA identified an Immediate Jeopardy (IJ) on 10/6/2019 at 7:28 PM, when Resident #74 was found unresponsive and without a pulse or respirations by the facility staff. The facility staff failed to verify Resident #74's code status. Cardiopulmonary Resuscitation (CPR) was initiated by the facility staff until the local Fire Department arrived at 7:35 PM, and reviewed Resident #74's chart where the DNR code status was documented. The CPR was stopped after five (5) minutes, and Resident #74 was pronounced deceased at 7:42 PM. The facility staff did not follow Resident #74's Care Plan regarding her DNR code status. The facility's failure to follow Resident #74's Comprehensive Care Plan regarding her DNR code status placed Resident #74 and other residents with a DNR code status in situations that was likely to cause serious harm, injury, impairment or death. On, 1/29/2020 at 12:05 PM, the State Agency	F 656	1. The Care plans for Resident #74, #31, #64 were reviewed and updated according to the advance directive and code status on 1/29/2020. Care plan for Resident #22 has been reviewed and updated to reflect to assess for pain prior to and during wound care on 11/27/2019. 2. All residents have the potential to be affected. 3. All resident care plans were reviewed and updated by the Care Plan Coordinator on 11/27/2019 to ensure the advance directives and code status are followed. All resident's care plans were reviewed and updated by the Care Plan Coordinator on 11/27/2019 to ensure that any resident who may have a wound will be assessed for pain prior to and during wound care. Care plans will be reviewed and updated weekly during the Interdisciplinary Care Plan Team meeting and as needed by the Care plan Coordinator effective 12/4/2019. 4. The care plans for new residents, residents who change their advance directive and residents with wounds will be reviewed by the Interdisciplinary Care Plan Team weekly to ensure accuracy and compliance effective 12/4/2019. The results will be discussed in the monthly		

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F 656	Continued From page 22 (SA) notified the facility's Administrator of the Immediate Jeopardy (IJ). The facility submitted an Acceptable Immediate Jeopardy Removal Plan on 1/30/2020, in which the facility alleged all corrective actions were completed on 1/30/2020, and the IJ was removed on 1/30/2020. The SA validated the facility's Immediate Jeopardy Removal Plan on 1/31/2020 and determined the IJ was removed on 1/30/2020, prior to exit. Findings Include: Record Review of the facility's policy titled, "Comprehensive Care Plans", dated 09/2018, revealed it is the policy of this facility to develop and implement a comprehensive person centered Care Plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #74 Review of Resident #74's Care Plan revealed the facility failed to follow the care plan regarding the resident's Do Not Resuscitate (DNR) code status. The Care Plan was initiated, on 7/25/2019, for Resident #74's DNR code status. The goal was to honor the resident and family wishes. The interventions included: Ensure comfort measures are achieved without heroics. Ensure resident/family understands meaning of code status. Label the chart, Medication Administration	F 656	Quality Assurance and Quality Assurance Performance Improvement meeting for review and recommendations by the committee.		

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F 656	Continued From page 23 Record (MAR) and Treatment Administration Record (TAR) to inform staff of DNR code status, obtain signed consent and Medical Doctors orders for DNR. Review of Resident #74's Progress Notes-Nursing Notes, dated 10/6/2019 at 9:18 PM, revealed a note at 7:28 PM stated the Charge Nurse, Medication (Med) cart nurse, Registered Nurse (RN) and three (3) Certified Nursing Assistants (CNAs) entered the room and Resident #74 was found unresponsive and no pulse. The resident was assisted to the floor via a sheet and Cardiopulmonary Resuscitation (CPR) was initiated per the American Heart Association protocol and 911 was called at 7:30 PM. The local Fire Department arrived at 7:35 PM and reviewed Resident #22's chart to discover the resident was a DNR. CPR was ceased at that time. Resident was pronounced at 7:42 PM. The Coroner arrived at 8:11 PM, and the resident's body was released to the funeral home at 8:32 PM. The Nurses Notes revealed CPR was performed for five (5) minutes, prior to the fire department's arrival. During an interview, on 11/26/19 at 5:25 PM, RN #4/Care Plan Nurse revealed he looks at the residents advance directives to determine whether the resident is a full code or a DNR. LPN #4 said he normally does a care plan for the resident with a DNR code status and he expected the staff to follow the care plan. Review of the facility's Advanced Care Planning form revealed Resident #74's printed name and her daughter's printed and signed name, dated 5/9/2018, for an elected DNR code status. Resident #74's Admission Record revealed the resident's daughters were the first and second	F 656			

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F 656	Continued From page 24 contact persons. The resident's Advanced Directive was a Do Not Resuscitate. Review of Resident #74's Physician's Orders revealed an order, dated 5/9/2018, for a DNR code status. Review of the Admission Record revealed Resident #74 was admitted by the facility, on 05/09/2018, with the included diagnoses Cardiomyopathy, Heart Failure, Cardiomegaly, Tachycardia, Pulmonary Disease and Chronic Atrial Fibrillation. Review of Resident #74's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/23/2019, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #22 Review of Resident #22's Care Plan revealed the Care Plan did not address pain assessment/management for wound care. Further review of the Care Plan revealed the Focus for risk for skin breakdown secondary to decreased mobility and history (hx) of occasional urinary incontinence was initiated, on 9/18/2019. The Goal stated the resident would be free of skin breakdown with a Target Date of 12/15/2019. Further review of the care plan revealed an Intervention, dated 10/24/2019, to cleanse the unstageable wound to the left heel with Normal Saline (NS), pat dry, apply Santyl to wound bed, apply sureprep to wound edges, apply adhesive dressing (dsy), wrap with kerlix, daily (dly) and as needed (PRN) until healed. The Interventions	F 656			

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F 656	Continued From page 25 also included: Administer Ultram 50 milligrams (mg) by mouth (po) every (q) six (6) hours as needed (prn) for pain. Monitor effectiveness of prn medication and document. Notify Medical Doctor (MD) if medication not effective in helping relieve and/or control pain. An observation, on 11/26/2019 at 9:00 AM, revealed Registered Nurse (RN) #3/Wound Care Nurse, did not follow Resident #22's Care Plan due to she did not assess the residents gestures and verbalization of pain/discomfort during the wound care observation, or administer pain medication. Registered Nurse (RN) #3/Wound Care Nurse, was assisted by Certified Nursing Assistant (CNA) #1. Resident #22 was observed lying comfortably in bed on her right side. When RN #3 began to clean the wound with NS, Resident #22 cried out "OWWWW" and drew her left leg upward toward her chest, during the wound care. RN #3 confirmed Resident #22 did not receive pain medication prior to wound care. RN #3 continued to clean Resident #22's wound with NS. RN #3 measured the wound, washed her hands, applied gloves and cleaned the wound again. Resident #22 cried out "OWWWW" a second time. RN #3 continued to preform the wound care until complete without assessing Resident #22's pain or providing pain medication. Resident #22's left heel wound measured 1.4 centimeter (cm) by 1.2 cm, with 50% slough, mild clear drainage, and no odor. An interview, on 11/26/2019 at 11:00 AM, with RN #3/Wound Care Nurse, revealed Resident #22 did not receive pain medication prior to the wound care to the left heel. RN #3/Wound Care Nurse stated Resident #22 usually does not complain of pain. RN #3/Wound Care Nurse stated she	F 656			

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F 656	Continued From page 26 should have stopped the treatment when the resident complained of pain. Review of Resident #22's Order Review Report revealed an order, dated 10/24/2019, to cleanse the unstageable left heel wound with NS, pat dry, apply santyl to wound bed. Apply sureprep to wound edges. Apply adhesive foam dressing. Wrap with kerlix daily and PRN until healed, every day shift and as needed. Further review of the report revealed an order, dated 9/16/2019, for Ultram Tablet 50 milligrams (mg), give one (1) tablet by mouth every six (6) hours as needed for pain. There also was an order, dated 6/28/2019, to administer Tylenol tablet, give 1000 mg by mouth daily for pain. During an interview, on 11/26/19 at 5:33 PM, RN #4/Care Plan Nurse confirmed the facility failed to develop a care plan related to pain regarding Resident #22's left heel wound care. RN #4/Care Plan Nurse said he developed a care plan today, and he notified the doctor of Resident #22's wound care pain and received an order for pain medication routinely and as needed. An interview, on 11/26/2019 at 5:58 PM, revealed the Director of Nurses (DON) stated, "I would have stopped as soon as the resident cried out in pain during the wound care treatment and got her some pain medication". Review of the Face Sheet revealed Resident #22 was admitted by the facility, on 4/30/2012, with the included diagnoses of Chronic Kidney Disease, Urinary Retention and Vascular Dementia with behavioral Disturbance. A review of Resident #22's Quarterly Minimum	F 656			

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F 656	Continued From page 27 Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/2019, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired. Further review of the MDS revealed the presence of an unstageable pressure ulcer suspected of deep tissue injury evolution. Review of the resident's pain assessment revealed she received routine pain medication, but no as needed pain medication. The pain interview was not done. This is the facility's accepted Immediate Jeopardy Removal Plan: Summary of events: The State Agency notified Azalea Gardens Nursing Center on January 29th, 2020 at 12:05 P.M. of the immediate jeopardy and substandard quality of care for Residents #74, #31, and #64. The Facility failed to honor Resident #74's advance directive for a do not resuscitate (DNR) code status, failed to honor the Resident's Rights for Advance Directive, failed to follow the care plan for a DNR code status and failed to prevent a potential negative outcome by initiating Cardiopulmonary Resuscitation (CPR). Resident #74 was found pulseless on October 6th, 2019 at 7:28 PM by RN #1 who initiated Cardiopulmonary Resuscitation (CPR) for a total of five minutes. CPR was discontinued when emergency services arrived and notified RN #1 of Resident #74's DNR code status. RN #1 failed to follow the policy and procedures in place to identify Resident #74's code status. The State Agency notified the facility on January 28th, 2020 at 3:30 PM that Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status	F 656			

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F 656	Continued From page 28 was not in the Electronic Health Record, according to their wishes which could have likely caused harm for Residents #31 and #64. The facility failed to follow policy and procedure to identify the correct code status for Residents #74, #31, and #64. Facility action plan: 1. The Director of Nursing (DON) conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with Registered Nurse (RN) #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. On November 27th, 2019 Care Plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. On January 29th and 30th, 2020 the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. On November 27, 2019 the Assistant Director of Nursing (ADON) reviewed all code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies.	F 656			

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F 656	Continued From page 29 The findings were 55 DNR and 22 full code status. 6. On January 29th, 2020 at 12:05PM, the State Agency identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. Care Plan Nurse found that Resident #64's order had been discontinued by Licensed Practical Nurse (LPN) #1 and the order was reentered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status. 8. The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical	F 656			

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F 656	Continued From page 30 Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. No staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member. The facility alleges the immediate jeopardy be removed on January 30, 2020. On 1/31/2020, the State Agency (SA) validated the facility's Removal Plan by staff interviews, record reviews, review of in-service sign-in sheets, and review of documents across all	F 656			

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F 656	Continued From page 31 disciplines. The SA verified the facility had implemented the following measures to remove the IJ: 1. The SA validated through record review of the sign-in sheets and interview with the Director of Nursing (DON) that the facility conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with RN #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. The SA validated through record review of the in-service sign-in sheets and interview with the Care Plan Nurse that on November 27th, 2019 Care plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. The SA validated through record review of the sign-in sheets and interview with the DON that the facility conducted an in-service on December 24th, 2019 at 1:30 PM, by the Director of Nursing, to all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. The SA validated through record review of the in-service sign-in sheets and interview with the facility owner that on January 29th and 30th, 2020, the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. The SA validated by interview of the ADON that on November 27, 2019 the ADON reviewed all code status records in each resident's paper	F 656			

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F 656	Continued From page 32 chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies. The findings were 55 DNR and 22 full code status. 6. The SA validated by record review and staff interviews, on January 29th, 2020 at 12:05 PM, the SA identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. The Care Plan Nurse found that Resident #64's order had been discontinued by LPN #1 and the order was re-entered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by the Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The SA validated by interviews the Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status.	F 656			

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F 656	Continued From page 33 8. The SA validated through interviews with the Facility Administrator and the DON the Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. The SA validated through interviews with the Administrator and the DON that no staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on	F 656			

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F 656	Continued From page 34 identifying code status with understanding expressed by staff member. The SA validated that all corrective actions to remove the IJ had been completed as of 1/30/2020, and the IJ was removed on 1/31/2020, prior to exit.	F 656			
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 interviews, record review and facility policy review, the facility failed to honor Resident #74's Do Not Resuscitate (DNR) code status by initiating Cardio-Pulmonary Resuscitation (CPR) when the resident was found by the facility staff unresponsive and with no pulse or respirations, for one (1) of four (4) residents reviewed who had expired in the facility within the past six (6) months. The State Agency identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 10/6/2019. Resident #74 had a Physician's Order and Advance Directive for a Do Not Resuscitate (DNR) code status dated 5/9/2018 and was found by staff, on 10/6/2019 at 7:28 PM, without a pulse or respirations. CPR was initiated by the facility's staff for five (5) minutes until the local Fire Department arrived. CPR was stopped due to the Fire Department	F 678	1. On 10/6/2019 at 7:28 PM, resident #74 was found unresponsive and Cardiopulmonary Resuscitation was initiated by the Nurse. The Nurse failed to check the resident's code status and initiated Cardiopulmonary Resuscitation. Cardiopulmonary Resuscitation was continued on Resident #74 by the Nurse for five minutes until emergency services arrived and notified the Nurse of a do not resuscitate code status. Cardiopulmonary Resuscitation was discontinued on resident #74 at this time. Resident #74 had a physician order dated 5/9/2018 for a do not resuscitate code status and an Advance Directive dated for 5/9/2018 stating do not resuscitate. Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status was not in		2/28/20

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F 678	Continued From page 35 staff reviewed the resident's chart and discovered the DNR code status. Resident #74 was never revived and was pronounced deceased at the facility. The facility's failure to honor Resident #74's DNR code status, placed this resident and other residents with a DNR code status, in a situation that was likely to cause serious harm, injury, impairment or death. The facility Administrator was notified of the IJ and SQC on 1/29/2020. The State Agency (SA) received an acceptable Immediate Jeopardy Removal Plan on 1/30/2020, in which the facility alleged that all corrective actions were completed as of 1/30/2020, and the Immediate Jeopardy was removed on 1/30/20. The SA determined the IJ was removed on 1/30/2020 prior to the SA's exit on 1/31/2020. Findings Include: Review of the facility's policy titled, "Cardiopulmonary Resuscitation (CPR)", dated October 2018, revealed it is the policy of the facility to adhere to resident's rights to formulate the advance directives. In accordance to these rights, the facility will implement guidelines regarding Cardio-pulmonary Resuscitation (CPR). The facility will follow current American Heart Association (AHA) guidelines regarding CPR. If a resident experience a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and in accordance with the resident's advance directives, or in the absence of advance	F 678	the Electronic Health Record, according to their wishes which could have caused harm for Residents #31 and #64. The Nurse was in-serviced on 10/8/2019 by the Director of Nursing. The Nurse Supervisor was separated of her job duties on 1/31/2020 as a disciplinary action. 2. All residents have the potential to be affected. 3. The Director of Nursing conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. On November 27th, 2019, the Care Plan Nurse conducted in services for all licensed nurses from 7:30 AM to 5:30 PM on initiating Cardiopulmonary Resuscitation and how to identify resident code status. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the right to choose code status and Cardiopulmonary Resuscitation policies. On January 29th and 30th, 2020, the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedures related to communication of code status with all licensed nurses.		

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F 678	Continued From page 36 directives, or Do Not Resuscitate order and/ or if the resident does not show obvious signs of clinical death (e.g. rigor mortis, decapitation, transection, or decomposition). Review of the facility's policy titled, "Advance Directives" dated November 2018, revealed the Advance Directives will be respected in accordance with state law and facility policy. The policy guidelines stated that upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an Advance Directive if he or she chooses to do so. Information about whether the resident has executed an Advance Directive shall be displayed prominently in the medical record. If the resident indicates that he or she has not established Advance Directives, the facility staff should offer assistance in establishing advance directives. The resident has the right to refuse treatment, whether he or she has an Advance Directive. A resident will not be treated against his or her own wishes. The facility states the Advance Directive policy is a written instruction such as a living will or durable power of attorney for health care, recognized by state law, relating to the provisions of health care when the individual is incapacitated. The facility's Do Not Resuscitate (DNR) definition indicated, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life sustaining treatments or methods are to be used. Review of the facility's "Resident Rights" policy, dated January 2019, revealed the facility will inform the residents both orally and in writing in a	F 678	On January 29th, 2020 beginning at 1:30 PM and ending on January 30th, 2020 3:00 PM all staff was in serviced by the Administrator and the Director of Nursing to include assistance with code and code location in the event of an emergency. The Director of Nursing conducted an in service on January 31st, 2020 at 1:24 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. The Director of Nursing conducted an in service on February 28th, 2020 at 1:24 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. 4. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. A plan of action was implemented on 12/13/2019 to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status. The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow facility policies or procedures related to the code status of each resident. A plan of action was implemented on 1/29/2020 to ensure that all licensed nurses were in serviced on the Advance Directive Protocol for Determining Code Status. All resident		

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F 678	Continued From page 37 language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Prior to or upon admission the social service designee, or another designated staff member, will inform the resident and or the resident's representative of the resident's rights and responsibilities. The facility will protect and promote the rights of the resident. Review of the Progress Notes-Nursing Notes, dated 10/6/2019 at 9:18 PM, revealed a note at 7:28 PM stated the Charge Nurse, Medication (Med) cart nurse, Registered Nurse (RN) and three (3) Certified Nursing Assistants (CNAs) entered the room and Resident #74 was found unresponsive and no pulse. The resident was assisted to the floor via a sheet and Cardiopulmonary Resuscitation (CPR) was initiated per the American Heart Association protocol and 911 was called at 7:30 PM. The local Fire Department arrived at 7:35 PM and the resident's chart was reviewed to discover the resident was a DNR. CPR was ceased at that time. Resident was pronounced deceased at 7:42 PM. The Coroner arrived at 8:11 PM, and the resident's body was released to the funeral home at 8:32 PM. The Nurses Notes revealed CPR was performed for five (5) minutes, prior to the fire department's arrival. Registered Nurse (RN) #1/Supervisor was interviewed on 1/30/2020 at 3:24 PM. RN #1/Supervisor confirmed she did not ask anybody to get Resident #74's chart until the Fire Department personnel asked for it. RN #1/Supervisor said she did not know what happened, it happened so quick. RN #1/Supervisor stated RN #1 and LPN #5 initiated	F 678	charts were audited on 1/29/2020 to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit on 1/29/2020 and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies were reviewed on 1/29/2020 and no revisions were required. The Quality Assurance Committee met on January 31st, 2020 to discuss the implementation of the facilities action plan to prevent any future adverse events. The facility will audit each residents code status daily for five days beginning February 3rd 2020, weekly for four weeks, then monthly for six months with a 100% success rate ending September 31st, 2020. The audit will include the residents name, electronic health record, condition alert, face sheet, care plan and written physicians' orders. The audits will be documented and completed with a signature from two Administrative Nurses beginning 2/3/2020, presented to the Quality Assurance Nurse for review and presented to the monthly Quality Assurance Committee and Quality Assurance Performance Improvement Program Committee for review and recommendation. If 100% accuracy is not achieved an immediate action plan will be developed and implemented. The Director of Nursing will conduct a mock code drill to include policy and procedure related to advance directives and code status with individual nurses		

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F 678	Continued From page 38 the CPR, and when she looked up the Fire Department was already there, and that's when they checked the chart for the code status. RN #1/Supervisor said they had received a call from the lab reporting a critically high Potassium level, and the Medical Doctor (MD) instructed them to send Resident #74 to the Emergency Room (ER) for evaluation and treatment. Resident #74 was left alone in the room with the Certified Nursing Assistant (CNA). RN #1/Supervisor said she could not remember who the CNA was. RN #1/Supervisor reported the CNA came to the door saying, "I don't think she's breathing". RN #1/Supervisor stated RN #5 and Licensed Practical Nurse (LPN) #2 initiated CPR, and when she entered the room she instructed another CNA to call 911. RN #1/Supervisor said when she looked up the Fire Department was at the facility, and that was when Resident #74's DNR status was identified. RN #1 did say she had been in-serviced several times on where to look for a resident's code status. Review of the Progress Notes-Nurses Notes, dated 10/6/2019 at 7:17 PM, confirmed a call was received from (Name of Hospital) lab reporting a critically high Potassium level of 8.7, which was reported to (Name of MD) who instructed to send resident to (Name of Hospital) to be evaluated and treated. (Names of Contact Persons) were notified and verbalized understanding. RN #5/Charge Nurse was interviewed, on 1/30/2020 at 3:30 PM. RN #5/Charge Nurse said she did not ask anybody to get the chart to identify Resident #74's code status. RN #5/Charge Nurse said she provided chest compressions and LPN #2 provided mouth to mouth breathing. RN #5/Charge Nurse said she	F 678	randomly for six months beginning January 1st, 2020 and ending June 31st, 2020. The director of Nursing will report findings to the Quality Assurance and Quality Assurance Performance Improvement program committee for review and recommendation.		

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F 678	Continued From page 39 did not ask anybody to get the chart because she thought RN #1/Supervisor had checked the chart for the code status. RN #5 said she was called into the room by a CNA. An interview, on 1/30/2020 at 3:59 PM, with LPN #2 revealed she had been trained where the code status was located in the resident's chart. LPN #2 confirmed she did not ask anybody to get the chart because she thought RN #5/Charge Nurse checked Resident #74's chart for the code status. LPN #2 said she did assist RN #5/Charge Nurse with resuscitating Resident #74. The Medical Director was interviewed, on 1/29/2020 at 11:53 AM. The Medical Director stated Resident #74 could have had a negative outcome if she had survived with broken ribs or being placed on a ventilator. The Medical Director stated he was told the staff found Resident #74 unresponsive and initiated CPR. The Medical Director said CPR was performed until the Fire Chief pulled the resident's chart and noted she was a DNR, and the Fire Chief stopped the CPR at that moment. Review of the facility's Advanced Care Planning form revealed Resident #74's printed name and her daughter's printed and signed name, dated 5/9/2018, for an elected DNR code status. Resident #74's Admission Record revealed the resident's daughters were the first and second contact persons. The resident's Advanced Directive was a Do Not Resuscitate. Review of Resident #74's Physician's Orders revealed an order, dated 5/9/2018, for a DNR code status.	F 678			

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F 678	Continued From page 40 An interview, on 11/26/2019 at 4:44 PM, revealed Firefighter #1 stated he responded to the call on 10/6/2019 when Resident #74 was found pulseless. Fire Fighter #1 stated the Chief reviewed Resident #74's medical records and found Resident #74 was a DNR. CPR was stopped at that time once they identified Resident #74 as a DNR. Fire Fighter #1 also stated that the Resident #74 was pronounced by the Fire Department and the coroner was notified. An interview, on 1/29/2020 at 12:22 PM, with the Assistant Director of Nurses (ADON) revealed Resident #74's DNR order was in the chart's Physician's Orders, and on the Medication Administration Record (MAR). The ADON stated she was responsible for checking the residents code status and making sure there's a written order that is in the electronic record and on the Medication Administration Record (MAR). The ADON revealed the orders for a DNR code status, and the resident's choice for a DNR code status was not followed by the nurses. An interview, on 11/26/2019 at 5:52 PM, revealed the Director of Nursing (DON) confirmed Resident #74 was found unresponsive on 10/6/2019, and Registered Nurse #5/Charge Nurse and Licensed Practical Nurse (LPN) #2 initiated CPR. The DON stated CPR ceased after Resident #74 was identified as a DNR by the local Fire Department when the chart was reviewed by them. The DON reported the nurses did not check the resident's code status, and as a result, Resident #74's DNR code status was not honored by the nurses who initiated the CPR. An interview, on 11/26/2019 at 4:46 PM, with the Deputy Coroner revealed he was informed by the	F 678			

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F 678	Continued From page 41 facility staff Resident #74 was never revived, and the fire department had already pronounced the resident by the time he arrived. Review of the Admission Record revealed Resident #74 was admitted by the facility, on 05/09/2018, with the included diagnoses Cardiomyopathy, Heart Failure, Cardiomegaly, Tachycardia, Pulmonary Disease and Chronic Atrial Fibrillation. Review of Resident #74's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/23/2019, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. This is the facility's accepted Immediate Jeopardy Removal Plan: Summary of events: The State Agency notified Azalea Gardens Nursing Center on January 29th, 2020 at 12:05 P.M. of the immediate jeopardy and substandard quality of care for Residents #74, #31, and #64. The Facility failed to honor Resident #74's advance directive for a do not resuscitate (DNR) code status, failed to honor the Resident's Rights for Advance Directive, failed to follow the care plan for a DNR code status and failed to prevent a potential negative outcome by initiating Cardiopulmonary Resuscitation (CPR). Resident #74 was found pulseless on October 6th, 2019 at 7:28 PM by RN #1 who initiated Cardiopulmonary Resuscitation (CPR) for a total of five minutes. CPR was discontinued when emergency services arrived and notified RN #1 of Resident#74's DNR	F 678		

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F 678	Continued From page 42 code status. RN #1 failed to follow the policy and procedures in place to identify Resident #74's code status. The State Agency notified the facility on January 28th, 2020 at 3:30 PM that Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status was not in the Electronic Health Record, according to their wishes which could have likely caused harm for Residents #31 and #64. The facility failed to follow policy and procedure to identify the correct code status for Residents #74, #31, and #64. Facility action plan: 1. The Director of Nursing (DON) conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with Registered Nurse (RN) #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. On November 27th, 2019 Care Plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. On January 29th and 30th, 2020 the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. On November 27, 2019 the Assistant Director	F 678			

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F 678	Continued From page 43 of Nursing (ADON) reviewed all code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies. The findings were 55 DNR and 22 full code status. 6. On January 29th, 2020 at 12:05PM, the State Agency identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. Care Plan Nurse found that Resident #64's order had been discontinued by Licensed Practical Nurse (LPN) #1 and the order was reentered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status.	F 678			

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F 678	Continued From page 44 8. The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. No staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member.	F 678			

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F 678	Continued From page 45 The facility alleges the immediate jeopardy was removed on January 30, 2020. On 1/31/2020, the State Agency (SA) validated the facility's Removal Plan by staff interviews, record reviews, review of in-service sign-in sheets, and review of documents across all disciplines. The SA verified the facility had implemented the following measures to remove the IJ: 1. The SA validated through record review of the sign-in sheets and interview with the Director of Nursing (DON) that the facility conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with RN #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. The SA validated through record review of the in-service sign-in sheets and interview with the Care Plan Nurse that on November 27th, 2019 Care plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. The SA validated through record review of the sign-in sheets and interview with the DON that the facility conducted an in-service on December 24th, 2019 at 1:30 PM, by the Director of Nursing, to all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. The SA validated through record review of the in-service sign-in sheets and interview with the facility owner that on January 29th and 30th, 2020, the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to	F 678			

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F 678	Continued From page 46 discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. The SA validated by interview of the ADON that on November 27, 2019 the ADON reviewed all code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies. The findings were 55 DNR and 22 full code status. 6. The SA validated by record review and staff interviews, on January 29th, 2020 at 12:05 PM, the SA identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. The Care Plan Nurse found that Resident #64's order had been discontinued by LPN #1 and the order was re-entered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by the Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The SA validated by interviews the Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker,	F 678			

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F 678	Continued From page 47 Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status. 8. The SA validated through interviews with the Facility Administrator and the DON the Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the	F 678			

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F 678	Continued From page 48 physician order is responsible for communicating the directions in all relevant sections of the medical record. The SA validated through interviews with the Administrator and the DON that no staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member. The SA validated that all corrective actions to remove the IJ had been completed as of 1/30/2020, and the IJ removed on 1/31/2020, prior to exit.	F 678			
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to ensure Resident #74's choice for a Do Not Resuscitate (DNR) code status was honored. This was identified for one of four (1 of 4) residents reviewed who expired in the facility over the past six (6) months. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care	F 684	1. On 10/6/2019 at 7:28 PM, resident #74 was found unresponsive and Cardiopulmonary Resuscitation was initiated by the Nurse. The Nurse failed to check the resident's code status and initiated Cardiopulmonary Resuscitation. Cardiopulmonary Resuscitation was continued on Resident #74 by the Nurse for five minutes until emergency services		2/28/20

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F 684	Continued From page 49 (SQC) on 10/6/2019. Resident #74 had a Physician's Order and an Advanced Directive, dated 5/9/2018, for a DNR code status. On 10/6/2019 at 7:38 PM, Resident #74 was found unresponsive, and without a pulse or respirations by the facility's staff. Cardiopulmonary Resuscitation (CPR) was initiated by the facility's staff and the Emergency Medical System (EMS) was notified. The local Fire Department was dispatched to the facility. Resident #74's chart was checked by the Fire Chief on arrival to the facility and it was discovered at that time Resident #74 was a DNR. CPR had been in progress five (5) minutes and was stopped by the Fire Chief at that time. Resident #74 was not revived during the CPR and was pronounced deceased at the facility. The facility's staff did not check Resident #74's chart to verify her choice of code status was a DNR, and CPR should not have been initiated. The facility's failure to honor Resident #74's choice for a DNR code status, placed Resident #74 and other residents with a DNR code status, in a situation that was likely to cause serious harm, injury, impairment or death. The SA notified the facility's Administrator of the IJ and SQC on 1/29/2020. Findings Include: Review of the facility's, "Advance Directives Policy", dated 11/2018, revealed the Advance Directives will be respected in accordance with state law and facility policy. Information about whether the resident has executed an Advance Directive shall be displayed prominently in the medical record. A resident will not be treated	F 684	arrived and notified the Nurse of a do not resuscitate code status. Cardiopulmonary Resuscitation was discontinued on resident #74 at this time. Resident #74 had a physician order dated 5/9/2018 for a do not resuscitate code status and an Advance Directive dated for 5/9/2018 stating do not resuscitate. Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status was not in the Electronic Health Record, according to their wishes which could have caused harm for Residents #31 and #64. The Nurse was in-serviced on 10/8/2019 by the Director of Nursing. The Nurse Supervisor was separated of her job duties on 1/31/2020 as a disciplinary action. 2. All residents have the potential to be affected. 3. The Director of Nursing conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. On November 27th, 2019, the Care Plan Nurse conducted in services for all licensed nurses from 7:30 AM to 5:30 PM on initiating Cardiopulmonary Resuscitation and how to identify resident code status. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the		

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F 684	Continued From page 50 against his or her own wishes. The facility's Do Not Resuscitate (DNR) definition indicated that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life sustaining treatments or methods are to be used. Review of the Progress Notes - Nurses Notes, revealed, on 10/6/2019 at 7:28 PM, Resident #74 was found unresponsive and without a pulse. Resident #74 was assisted to the floor, and CPR was initiated by LPN #2 and RN #5. The Nurse's Notes stated 911 was called at 7:30 PM. The local Fire Department arrived at 7:35 PM and CPR was stopped at that time when the Fire Department staff checked Resident #74's code status on the medical record. Resident #74 was pronounced dead at 7:42 PM. The Nurse's Notes revealed Resident #74 was resuscitated for five (5) minutes, prior to the Fire Department's arrival. An interview with RN #1/Supervisor, on 1/30/2020 at 3:24 PM, revealed she failed to follow the facility's policy for Resident #74's DNR code status. RN #1 confirmed she did not ask anybody to get the chart until the Fire Department requested it, which resulted in Resident #74's DNR code status not being recognized. RN #1 stated she didn't know what happened, everything happened so quick. During an interview on 01/30/2020 at 3:30 PM, Registered Nurse (RN) #5 revealed she provided chest compressions and Licensed Practical Nurse (LPN) #2 provided the mouth to mouth breathing on 10/6/2019 when Resident #74 was found unresponsive and with no pulse or respirations. RN #5 stated she did not ask	F 684	right to choose code status and Cardiopulmonary Resuscitation policies. On January 29th and 30th, 2020, the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedures related to communication of code status with all licensed nurses. On January 29th, 2020 beginning at 1:30 PM and ending on January 30th, 2020 3:00 PM all staff was in serviced by the Administrator and the Director of Nursing to include assistance with code and code location in the event of an emergency. The Director of Nursing conducted an in service on January 31st, 2020 at 1:24 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. The Director of Nursing conducted an in service on February 28th, 2020 at 1:24 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. 4. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. A plan of action was implemented on 12/13/2019 to ensure that all licensed nurses were in serviced on honoring Residents' Rights		

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F 684	Continued From page 51 anybody to get the resident's chart to verify the code status because she thought RN #1/Supervisor had done that. RN #5 revealed she was called into Resident #74's room by a Certified Nursing Assistant (CNA). RN #1/Supervisor was present at this time of the interview and stated she was in the room and they relieved each other until the Fire Department got there. Failure of the facility's staff to verify Resident #74's code status prior to initiating CPR resulted in the resident's Advance Directive choice for a DNR code status not being honored. Review of the facility's Advanced Care Planning form revealed Resident #74's printed name and her daughter's printed and signed name, dated 5/9/2018, for an elected DNR code status. Resident #74's Admission Record revealed the resident's daughters were the first and second contact persons. The resident's Advanced Directive was a Do Not Resuscitate. Review of Resident #74's Physician's Orders revealed an order, dated 5/9/2018, for a DNR code status. During an interview, on 01/30/2020 at 3:59 PM, LPN #2, stated she did assist RN #5 with resuscitating Resident #74 on 10/6/2019. LPN #2 also confirmed she did not ask anybody to get the chart to review Resident #74's code status. LPN #2 also stated she thought the supervisor had checked the chart for Resident #74's code status. LPN #2 stated she has been trained several times on where the code status was located. Review of Resident #74's Care Plan, dated 7/25/2019, revealed Resident #74's code status was Do Not Resuscitate (DNR). The goal is to	F 684	and the right to choose a code status. The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow facility policies or procedures related to the code status of each resident. A plan of action was implemented on 1/29/2020 to ensure that all licensed nurses were in serviced on the Advance Directive Protocol for Determining Code Status. All resident charts were audited on 1/29/2020 to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit on 1/29/2020 and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies were reviewed on 1/29/2020 and no revisions were required. The Quality Assurance Committee met on January 31st, 2020 to discuss the implementation of the facilities action plan to prevent any future adverse events. The facility will audit each residents code status daily for five days beginning February 3rd 2020, weekly for four weeks, then monthly for six months with a 100% success rate ending September 31st, 2020. The audit will include the residents name, electronic health record, condition alert, face sheet, care plan and written physicians' orders. The audits will be documented and completed with a signature from two Administrative Nurses beginning 2/3/2020, presented to the Quality Assurance Nurse for review and		

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F 684	Continued From page 52 honor the resident and family wishes. The interventions are to ensure comfort measures are achieved without heroics, ensure resident/family understands meaning of code status, label the chart, Medication Administration Record (MAR) and Treatment Administration Record (TAR) to inform staff of DNR code status, obtain signed consent and Medical Doctors order's for DNR. Fire Fighter #1's interview, on 11/26/2019 at 4:44 PM, revealed he responded to the call the night Resident #74 died. Firefighter #1 revealed CPR was in process by the facility staff on arrival, and the Fire Chief reviewed the medical records and confirmed Resident #74 was a DNR code status and CPR was discontinued. The Director of Nurse's (DONs) interview, on 11/26/2019 at 5:52 PM, confirmed RN #5/Charge Nurse found Resident #74 unresponsive, without a pulse and initiated CPR. The DON stated that CPR was stopped after the Fire Department found Resident #74 was a DNR code status on review of the resident's medical records. The DON confirmed Resident #74 was a DNR code status, and the CPR should not have been initiated. The DNR code status was located on the resident's medical record. The Medical Director's interview, on 01/29/2020 at 11:53 AM, revealed he was informed staff found Resident #74 unresponsive and CPR was initiated. The Medical Director stated Resident #74 could have had a negative outcome of surviving with broken ribs or being placed on a ventilator. Review of the Admissions Record revealed Resident #74 was admitted by the facility, on	F 684	presented to the monthly Quality Assurance Committee and Quality Assurance Performance Improvement Program Committee for review and recommendation. If 100% accuracy is not achieved an immediate action plan will be developed and implemented. The Director of Nursing will conduct a mock code drill to include policy and procedure related to advance directives and code status with individual nurses randomly for six months beginning January 1st, 2020 and ending June 31st, 2020. The director of Nursing will report findings to the Quality Assurance and Quality Assurance Performance Improvement program committee for review and recommendation.		

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F 684	Continued From page 53 05/09/2018, with the included diagnoses of Cardiomyopathy, Heart Failure, Cardiomegaly, Tachycardia, Pulmonary Disease and Chronic Atrial Fibrillation. A review of Resident #74's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/23/2019 revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. This is the facility's accepted Immediate Jeopardy Removal Plan: Summary of events: The State Agency notified Azalea Gardens Nursing Center on January 29th, 2020 at 12:05 P.M. of the immediate jeopardy and substandard quality of care for Residents #74, #31, and #64. The Facility failed to honor Resident #74's advance directive for a do not resuscitate (DNR) code status, failed to honor the Resident's Rights for Advance Directive, failed to follow the care plan for a DNR code status and failed to prevent a potential negative outcome by initiating Cardiopulmonary Resuscitation (CPR). Resident #74 was found pulseless on October 6th, 2019 at 7:28 PM by RN #1 who initiated Cardiopulmonary Resuscitation (CPR) for a total of five minutes. CPR was discontinued when emergency services arrived and notified RN #1 of Resident#74's DNR code status. RN #1 failed to follow the policy and procedures in place to identify Resident #74's code status. The State Agency notified the facility on January 28th, 2020 at 3:30 PM that Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status	F 684			

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F 684	Continued From page 54 was not in the Electronic Health Record, according to their wishes which could have likely caused harm for Residents #31 and #64. The facility failed to follow policy and procedure to identify the correct code status for Residents #74, #31, and #64. Facility action plan: 1. The Director of Nursing (DON) conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with Registered Nurse (RN) #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. On November 27th, 2019 Care Plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. On January 29th and 30th, 2020 the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. On November 27, 2019 the Assistant Director of Nursing (ADON) reviewed all code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies.	F 684			

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F 684	Continued From page 55 The findings were 55 DNR and 22 full code status. 6. On January 29th, 2020 at 12:05PM, the State Agency identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. Care Plan Nurse found that Resident #64's order had been discontinued by Licensed Practical Nurse (LPN) #1 and the order was reentered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status. 8. The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that	F 684			

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F 684	Continued From page 56 met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. No staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member. The facility alleges the immediate jeopardy be removed on January 30, 2020. On 1/31/2020, the State Agency (SA) validated the facility's Removal Plan by staff interviews, record reviews, review of in-service sign-in	F 684			

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F 684	Continued From page 57 sheets, and review of documents across all disciplines. The SA verified the facility had implemented the following measures to remove the IJ: 1. The SA validated through record review of the sign-in sheets and interview with the Director of Nursing (DON) that the facility conducted an in-service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with RN #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. The SA validated through record review of the in-service sign-in sheets and interview with the Care Plan Nurse that on November 27th, 2019 Care plan Nurse conducted in-services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. The SA validated through record review of the sign-in sheets and interview with the DON that the facility conducted an in-service on December 24th, 2019 at 1:30 PM, by the Director of Nursing, to all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. The SA validated through record review of the in-service sign-in sheets and interview with the facility owner that on January 29th and 30th, 2020, the owner of the facility conducted an in-service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. The SA validated by interview of the ADON that on November 27, 2019 the ADON reviewed all	F 684			

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F 684	Continued From page 58 code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies. The findings were 55 DNR and 22 full code status. 6. The SA validated by record review and staff interviews, on January 29th, 2020 at 12:05 PM, the SA identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. The Care Plan Nurse found that Resident #64's order had been discontinued by LPN #1 and the order was re-entered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by the Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The SA validated by interviews the Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code	F 684			

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F 684	Continued From page 59 status. 8. The SA validated through interviews with the Facility Administrator and the DON the Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. The SA validated through interviews with the Administrator and the DON that no staff will be	F 684			

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F 684	Continued From page 60 allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member. The SA validated that all corrective actions to remove the IJ had been completed as of 1/30/2020, and the IJ removed on 1/31/2020, prior to exit.	F 684			
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to assess or administer pain medication for Resident #22's gestures and verbalization of pain/comfort during wound care. Resident #22's wound care was observed, 11/26/2019 at 9:00 AM. Resident #22 exhibited gestures and verbalization of pain, such a pulling her left leg up and saying "Owww" twice during the treatment. The wound was located on the left heel. Resident #22 was not assessed by the Treatment Nurse neither time, and therefore no pain medication was offered or administered. Resident #22 had orders for a pain medication every (6) six hours as needed. As a result, the nurse's failure to assess and administer Resident #22's pain medication during the wound care observation, raised this concern to a harm level. This concern	F 697	1. On 11/26/2019 at 9:00 AM Resident #22 received wound care treatment. During observation of Resident #22's wound care treatment the Wound Care Nurse failed to assess the resident for pain at the time of treatment. Resident #22 was assessed for pain during wound care on 11/26/2019 at 9:00 AM by the Registered Nurse. The Physician was notified of pain and discomfort during wound care treatment and an order was given by the physician to medicate the resident thirty minutes to one hour prior to wound care. The Registered Nurse was in served regarding pain management before wound care on 11/26/2019 at 10:00 AM by the Director of Nursing. All residents with wound treatments were	2/28/20	

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F 697	Continued From page 61 was identified for one of eight (1 of 8) residents reviewed for pain. Findings include: Review of the facility's policy titled, "Pain Management", dated 11/2018, revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The facility utilizes a systematic approach for recognition, assessment, treatment and monitoring of pain. In order to help a resident, attain or maintain their highest practicable level of well-being and to prevent or manage pain, the facility should: a. Recognize when the resident's experiencing pain and identifies circumstances when the pain is anticipated; b. Evaluate the resident for pain upon admission, during ongoing scheduled assessments, and with change in condition or status (e.g., after a fall with change in behavior or mental status). c. Manages or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. An observation, on 11/26/2019 at 9:00 AM, revealed Registered Nurse (RN) #3/Wound Care Nurse, failed to assess Resident #22's gestures and verbalization of pain/discomfort during the wound care. Registered Nurse (RN) #3/Wound Care Nurse, was assisted by Certified Nursing Assistant (CNA) #1. Resident #22 was initially observed lying comfortably in bed on her right side. When RN #3 began to clean the wound with	F 697	evaluated for potential pain associated with wound care on 11/27/2019 by the Registered Nurse. 2.All residents with wounds have the potential to be affected. 3.All nurses were in serviced on pain management related to wound care and treatments on 11/27/2019 beginning at 7:00 AM and ending at 7:00 PM by the Director of Nursing. All residents with wound treatments were evaluated for potential pain associated with wound care on 11/27/2019 by the Registered Nurse. An assessment tab was added to the treatment log on 12/24/2019 to document potential pain prior to and during wound treatment by the Assistant Director of Nursing. All nurses were in serviced by the Director of Nursing completed on 12/24/2019 beginning at 7:00 AM ending at 4:00 PM implementing the pain assessment tab. 4. Wound care observations and audits were conducted weekly by the Director of Nursing beginning on 12/3/2019 and ending on 1/9/2020 with 100% success rate. The findings were reported on 1/10/2020 to the Quality Assurance Committee for review and recommendation. All residents with wounds will be discussed weekly beginning 12/3/2019 during the care plan meeting. The results will be reported monthly to the Quality Assurance and Quality Assurance Performance Improvement committee for review and		

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F 697	Continued From page 62 NS, Resident #22 cried out "OWWW" and drew her left leg upward toward her chest, during the wound care. RN #3 confirmed Resident #22 did not receive pain medication prior to wound care. RN #3 continued to clean Resident #22's wound with NS. RN #3 measured the wound, washed her hands, applied gloves and cleaned the wound again. Resident #22 cried out "OWWW" a second time. RN #3 continued to preform the wound care until complete without assessing Resident #22's pain or providing pain medication. Resident #22's left heel wound measured 1.4 centimeter (cm) by 1.2 cm, with 50% slough, mild clear drainage, and no odor. During an interview, on 11/26/2019 at 11:00 AM, RN #3 confirmed she did not stop to assess Resident #22's pain level during the wound care. RN #3 stated Resident #22 did not receive any pain medication prior to the wound care treatment. RN #3 stated Resident #22 normally does not complain of pain. RN #3 confirmed she should have stopped the treatment when Resident #22 complained of pain to assess her pain and administer pain medication. RN #3 said she thought the State Agency (SA) would have a problem with her stopping the treatment. During an interview, on 11/26/2019 at 10:00 AM, CNA #1 stated Resident #22 only complains of pain when the nurses does the wound care. Review of Resident #22's Order Review Report revealed an order, dated 10/24/2019, to cleanse the unstageable left heel wound with NS, pat dry, apply santyl to wound bed. Apply sureprep to wound edges. Apply adhesive foam dressing. Wrap with kerlix daily and PRN until healed, every day shift and as needed. Further review of the	F 697	recommendations.		

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F 697	Continued From page 63 report revealed an order, dated 9/16/2019, for Ultram Tablet 50 milligrams (mg), give one (1) tablet by mouth every six (6) hours as needed for pain. There also was an order, dated 6/28/2019, to administer Tylenol tablet, give 1000 mg by mouth daily for pain. During an interview, on 11/26/2019 at 5:58 PM, the Director of Nursing (DON) stated residents are assessed prior to wound care treatments. The DON stated, "I would have stopped as soon as the resident cried out in pain during the wound treatment and got her some pain medication." Review of Resident #22's Medical Record revealed she was hospitalized 6/12/2019 to 6/15/2019 after a fall. Resident #22 returned to the facility on 6/15/2019 status post a left hip replacement and was identified with soft heels. Sureprep was ordered to both heels as well as off loading. Further review of Resident #22's wound/skin assessments revealed: On 6/29/2019, the left heel was staged a Deep Tissue Injury (DTI) measuring 3.7 cm x 3.2 cm dark purple area with treatment continued. On 7/25/2019 the left heel measured 2.2 cm x 2.7 cm, black and firm. On 8/29/2019, the left heel measured 1.8 cm x 1.7 cm. On 9/26/2019 the left heel measured 1.5 cm x 1.5 cm with treatment continuing. On 10/31/2019 the left heel measured 1.5 cm x 2.0 cm. On 11/21/2019 the left heel measured 1.4 cm x 1.2 cm with continued treatment. Gradual slow healing. An interview, on 11/26/2019 at 9:45 AM, revealed the Director of Nurses (DON) stated Resident #22's heels were soft on return to the facility from the hospital on 6/15/2019 due to a left hip replacement. The DON stated the Wound Care	F 697			

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F 697	Continued From page 64 Nurse put treatments into place. The DON stated we are seeing improvement, but it is a slow gradual healing. Review of the Admission Record revealed the facility admitted Resident #22, on 4/30/2012, with the included diagnoses of Unstageable Left Heel Wound, Alzheimer's Disease, Osteoarthritis, Chronic Kidney Disease and Atherosclerotic Heart Disease. Review of Resident #22's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/19, revealed Resident #22 had a Brief Interview of Mental Status (BIMS) score 3, which indicated the resident was severely cognitively impaired. Further review of the MDS revealed the presence of an unstageable pressure ulcer suspected of deep tissue injury evolution. Review of the resident's pain assessment revealed she received routine pain medication, but no as needed pain medication. The pain interview was not done.	F 697			
F 867 SS=J	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to monitor, review, and evaluate their Quality Assessment and Assurance (QAA) plan to identify and document	F 867	1. The facility failed to monitor a plan of correction established by the facility's Quality Assurance Committee regarding resident #74, #31, #64. On 10/6/2019 at	2/28/20	

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F 867	Continued From page 65 the resident's Advance Directive choice for code status. During the initial recertification survey on 11/25/2019 to 11/27/2019, the State Agency (SA) identified the facility's failure to honor Resident #74's Do No Resuscitate (DNR) code status, on 10/6/2019, when the resident was found unresponsive, and without a pulse and respirations. The facility staff initiated Cardiopulmonary Resuscitation (CPR), which continued for five (5) minutes until the Fire Department arrived and reviewed the resident's medical record which revealed the DNR code status. Resident #74 was never revived and announced deceased at the facility. The SA also identified inaccurate code status documented for Resident #31 and #64 on re-entrance on 1/28/2020 to extend the survey to 1/31/2020. This concern was identified for three (3) of 78 (facility's census at time the SA re-entrance) resident code statuses reviewed. The SA identified an Immediate Jeopardy (IJ) on 1/29/2020, due to the facility's failure to ensure accurate and consistent information regarding resident code status to use in emergency situations. The QAA review showed the QAA committee was not aware of this systemic issue, and the QAA committee was not monitoring facility practices related to accurate and consistent communication of resident's Advance Directives regarding code statuses. The facility's QAA met on 12/13/2019 to discuss the facility's policy and procedure related to the code status for each resident. A plan of action was implemented to ensure all licensed nurses were in-serviced on honoring Resident's Rights and the right to choose a code status. The Director of Nurses (DON) provided an in-service, on 12/24/2019, to all licensed nurses on honoring	F 867	7:28 PM, resident #74 was found unresponsive and Cardiopulmonary Resuscitation was initiated by the Nurse. The Nurse failed to check the resident's code status and initiated Cardiopulmonary Resuscitation. Cardiopulmonary Resuscitation was continued on Resident #74 by the Nurse for five minutes until emergency services arrived and notified the Nurse of a do not resuscitate code status. Cardiopulmonary Resuscitation was discontinued on resident #74 at this time. Resident #74 had a physician order dated 5/9/2018 for a do not resuscitate code status and an Advance Directive dated for 5/9/2018 stating do not resuscitate. Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status was not in the Electronic Health Record, according to their wishes which could have caused harm for Residents #31 and #64. The Nurse was in-serviced on 10/8/2019 by the Director of Nursing. The Nurse Supervisor was separated of her job duties on 1/31/2020 as a disciplinary action. 2. All residents have the potential to be affected. 3. The Director of Nursing conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. On November 27th, 2019, the Care Plan		

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F 867	Continued From page 66 resident's rights, the right to choose a code status, and CPR policies. On, 11/27/2019, the Assistant Director of Nurses (ADON) reviewed all resident code status records in each resident's paper chart and compared that review to all of the resident's electronic health records, for a total of 77 records. The result was 55 residents were DNRs, and 22 were full code status. On 1/29/2020, the SA identified inaccurate code statuses for Resident's #31 and #64. The facility's failure to monitor the QAA's corrective plan to ensure the residents' Advance Directive regarding code status was accurate, placed Resident #74, #31, #64 and other residents with a DNR code status at risk for serious injury, harm, impairment or death. The facility Administrator was notified of the IJ on 1/29/2020 at 12:05 PM. The State Agency (SA) received an acceptable Immediate Jeopardy Removal Plan on 1/30/2020, in which the facility alleged that all corrective actions were completed as of 1/30/2020, and the Immediate Jeopardy was removed on 1/30/2020. The SA determined the IJ was removed on 1/30/2020, prior to the SA's exit on 1/31/2020. Findings include: Review of the facility's "Quality Assessment & Assurance (QAA) policy", dated 01/2019, revealed it is this facility's policy to develop, implement, and maintain an effective, comprehensive, data-driven QAA program that focuses on outcomes of care, promotes individual choice and the improvement in quality of life. The	F 867	Nurse conducted in services for all licensed nurses from 7:30 AM to 5:30 PM on initiating Cardiopulmonary Resuscitation and how to identify resident code status. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the right to choose code status and Cardiopulmonary Resuscitation policies. On January 29th and 30th, 2020, the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedures related to communication of code status with all licensed nurses. On January 29th, 2020 beginning at 1:30 PM and ending on January 30th, 2020 3:00 PM all staff was in serviced by the Administrator and the Director of Nursing to include assistance with code and code location in the event of an emergency. The Director of Nursing conducted an in service on January 31st, 2020 at 1:24 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor. The Director of Nursing conducted an in service on February 28th, 2020 at 1:24 PM to include return demonstration of a mock code drill, Communication of Code Status Policy and review of the Cardiopulmonary Resuscitation Policy with the Nurse Supervisor.		

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F 867	Continued From page 67 QAA Committee shall be interdisciplinary and shall consist at a minimum of: The Administrator, The Medical Director, The Director of Nursing, Infection Control Prevention Officer, two facility staff. The QAA Committee will: Conduct scheduled monthly meeting. Develop and implement appropriate plans of action to correct identified quality concerns and deficiencies. Participate in development, implementation and monitoring of the facilities written QAPI Plan. Regularly review and analyze performance data, including data collected under the QAPI (Quality Assurance and Performance Improvement) program, Infection Reports, Pharmacy, Psychological Reports, and recommendations. Identify issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program are necessary. Act on available data to make corrections or improvements. Review and evaluate all filed and completed grievances. Adverse events will be monitored in accordance with established procedures based on the type of adverse event. The data related to adverse events will be used to develop activities to prevent them. On 11/25/2019 at 2:39 PM, an interview with the Administrator revealed the facility held monthly QAA meetings. The Administrator stated new areas of concern are identified and a plan of correction is established. The Administrator stated the plan of correction included goals for resolutions. The Administrator stated old concerns are discussed for current status and if changes are needed. The Administrator revealed the concerns are identified from complaints/grievances, nursing reports, and general reporting by families, staff, and/or	F 867	4. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. A plan of action was implemented on 12/13/2019 to ensure that all licensed nurses were in serviced on honoring Residents ☐ Rights and the right to choose a code status. The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow facility policies or procedures related to the code status of each resident. A plan of action was implemented on 1/29/2020 to ensure that all licensed nurses were in serviced on the Advance Directive Protocol for Determining Code Status. All resident charts were audited on 1/29/2020 to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit on 1/29/2020 and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies were reviewed on 1/29/2020 and no revisions were required. The Quality Assurance Committee met on January 31st, 2020 to discuss the implementation of the facilities action plan to prevent any future adverse events. The facility will audit each residents code status daily for five days beginning February 3rd 2020, weekly for four weeks, then monthly for six months with a 100% success rate ending September 31st,		

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F 867	Continued From page 68 residents. Resident #74 The facility failed to monitor a plan of correction established by the facility's QAA regarding the resident's Advanced Directives regarding their code status was honored and documented correctly in the medical record. As a result per review of Resident #74's Progress Notes-Nursing Notes, dated 10/6/2019 at 9:18 PM, revealed a note at 7:28 PM documented Resident #74 was found by staff unresponsive and without a pulse or respirations. The staff initiated CPR. (Resident #74 was a Do Not Resuscitate (DNR) code status). The Emergency Medical System (EMS) was notified at 7:30 PM. The Fire Department arrived at 7:35 PM and checked the resident's chart and it was discovered at that time the resident was a DNR. The CPR was performed for five (5) minutes, until the Fire Department instructed the CPR to be stopped. Resident #74 was not revived and was pronounced deceased at 7:42 PM. The facility staff failed to check Resident #74's code status prior to initiating CPR. Review of Resident #74's Care Plan, dated 5/9/2019, revealed the resident was a DNR code status. Review of Resident #74's Physician's Orders revealed an order, dated 5/9/2018, for a DNR code status. Review of Resident #74's Advance Directive, dated 5/9/2018, revealed the resident and her daughter had elected a DNR code status. An interview with Registered Nurse (RN)	F 867	2020. The audit will include the residents name, electronic health record, condition alert, face sheet, care plan and written physicians' orders. The audits will be documented and completed with a signature from two Administrative Nurses beginning 2/3/2020, presented to the Quality Assurance Nurse for review and presented to the monthly Quality Assurance Committee and Quality Assurance Performance Improvement Program Committee for review and recommendation. If 100% accuracy is not achieved an immediate action plan will be developed and implemented. The Director of Nursing will conduct a mock code drill to include policy and procedure related to advance directives and code status with individual nurses randomly for six months beginning January 1st, 2020 and ending June 31st, 2020. The director of Nursing will report findings to the Quality Assurance and Quality Assurance Performance Improvement program committee for review and recommendation. The Quality Assurance Committee implemented a survey follow up form to be presented monthly to the Quality Assurance meeting on 1/29/2020. The follow up survey monitoring form will identify any systematic issues that are related to survey results. The issues will be immediately discussed and presented to the Quality Assurance Performance Improvement Committee for review and recommendation. Quality Assurance Committee will meet monthly and as needed to discuss any		

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F 867	Continued From page 69 #1/Supervisor, on 1/30/2020 at 3:24 PM, revealed she did not ask anyone to get Resident #74's chart to check the code status. RN #1/Supervisor confirmed the code status was not identified until the Fire Department personnel asked for the chart. RN #1 said she had been in-serviced regarding the location of the residents' code status, but everything happened so fast, and before she knew it the Fire Department was there. RN #1/Supervisor stated RN #5 and Licensed Practical Nurse (LPN) #2 initiated CPR, and when she entered the room, she instructed another Certified Nursing Assistant (CNA) to call 911. An interview with RN #5/Charge Nurse, on 1/30/2020 at 3:30 PM, revealed she did not ask anybody to get the chart to identify Resident #74's code status. RN #5/Charge Nurse said she did not ask anybody to get the chart because she thought RN #1/Supervisor had checked the chart for the code status. RN #5 said she was called into the room by a CNA. RN #5/Charge Nurse said she provided chest compressions and LPN #2 provided mouth to mouth breathing. Licensed Practical Nurse (LPN) #2 was interviewed on 1/30/2020 at 3:59 PM. LPN #2 revealed she did not ask anybody to get the chart because she thought RN #5/Charge Nurse checked Resident #74's chart for the code status. LPN #2 confirmed she did assist RN #5/Charge Nurse with resuscitating Resident #74. LPN #2 revealed she had been trained where the code status was located in the resident's chart. On 11/26/2019 at 5:52 PM, an interview with the Director of Nursing (DON), confirmed, on 10/6/2019, Resident #74 was found unresponsive	F 867	adverse events within the facility. The High Risk meetings will be held immediately to prevent any further adverse events and sent for review and recommendation by the Quality Assurance Performance Improvement committee.		

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F 867	Continued From page 70 and with no pulse or respirations. The DON confirmed Resident #74 was a DNR, and CPR was initiated by the facility staff until the Fire Department arrived and discovered the resident was a DNR. The DON revealed CPR was performed for five (5) minutes until the Fire Department's discovery of the DNR code status. The facility staff did not check the resident's chart to ensure the code status was identified and honored. Review of the facility's Quality Assessment and Assurance (QAA) sign in sheets dated 10/11/2019, 11/8/2019, 12/13/2019, 1/10/2019, 1/29/2020 and 1/31/2020 revealed the Medical Director, Administrator, Director of Nurses, Quality Assurance Nurse, Activity Director, Dietary Manager, Infection Preventionist, Social Worker, Minimum Data Set and Assistant Director of Nursing attended the QA meetings. The meeting on 12/13/2029 had a typed note attached stating, "Discussed policy and procedure related to code status. Discussed implementation and in-serving staff on policy and procedure related to code status." The 1/31/2020 notes addressed the discussion of (citation tag number), in-services conducted on resident code status, mock code drill with no issues identified. Discussed policy and procedure related to communication of code status, with no changes made. Discussed the facility's action plan to include audits of residents' code status, and all findings will be reported to QAPI. Review of the facility's In-Service Attendance Record, dated 12/24/2019, revealed the staff was trained on honoring Resident/family right to choose CPR and code status. Further review of the facility's In-Service Attendance Records	F 867			

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F 867	Continued From page 71 revealed the facility provided a training titled, Initiating CPR/Code Status to the licensed nurses, on 11/27/2019. An interview, on 1/30/2020 at 11:53 AM, revealed the Administrator confirmed the QAA committee failed to monitor their corrective actions to make sure all the resident's code status was correct. The Administrator also stated the system failed because their checks and balances did not work. The Administrator confirmed the system the QAA interdisciplinary team put in place was not successful. The Administrator stated the facility had a QAA meeting, on 10/11/2019, and discussed Resident #74's DNR code status. The Administrator stated the QAA committee considered this as a high risk situation and should be taken care of immediately. The Administrator stated the only thing the disciplinary team implemented during the meeting was to in-service the supervisors on where to locate the resident's code status and to perform a mock code. The Administrator stated the Quality Assurance (QA)/Infection Nurse schedules the QAA meetings monthly and as needed. The Administrator also stated the RN supervisors were in-serviced immediately on all shifts on how to locate the resident's code status in the chart, computer and Kiosk. The Administrator reported the RNs involved in the incident with Resident #74 did not receive any disciplinary actions from the facility. The Administrator stated the Assistant Director of Nursing (ADON) was responsible for checking the Physician's Orders, Quick Reference Sheet and the Medication Administration Records (MARS) to make sure the code statuses matched. The ADON was also responsible for monitoring all resident's code status. The Administrator said LPN #5 was the	F 867			

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F 867	Continued From page 72 acting QA/Infection Control Nurse, and was responsible for checking behind the ADON to make sure the resident's code status was updated. Review of the facility's In-Service Attendance Record, dated 10/8/2019, revealed the signatures of RN #1 and #5, regarding Code Status Simulation. On 1/29/2020 at 12:22 PM, an interview with the ADON revealed Resident #74's DNR status was not honored due to the nurses did not check her code status which was on the chart, the physician's orders, and the Medication Administration Record (MAR). Review of the Admission Record revealed Resident #74 was admitted by the facility, on 5/09/2018, with the included diagnoses of Cardiomyopathy, Cardiomegaly, Tachycardia, Pulmonary Disease, Heart Failure, and Chronic Atrial Fibrillation. A review of Resident #74's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/23/2019, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #31 Review of Resident #31 Quick Reference Sheet revealed Resident #31 was a Full Code. Review of the chart and current Electronic Physician's Orders revealed Resident #31 had elected to have a DNR code status.	F 867			

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F 867	Continued From page 73 On 1/29/2020 at 12:16 PM, an interview with LPN #5/Interim QA Nurse, revealed she did not know what happened with Resident #31's DNR code status not being on the Quick Reference Sheet. LPN #5 confirmed Resident #31 was a DNR, and should have been identified as such. LPN #5 stated she had only checked the new admissions since the last survey because all of the other charts had been checked. Resident #64 Review of Resident #64's Quick Reference Guide report sheet, revealed Resident #64 was listed as a DNR code status. Review of the current Physician's Orders revealed there was no code status order for a DNR. Further review revealed there was no code status on the Medication Administration Record (MAR). This is an additional check for code status for the facility. The MAR did not indicate a DNR because the nurse deleted it on the Physician's Orders which could have resulted in CPR being initiated instead of a DNR. An interview, on 1/30/2020 at 11:53 AM, revealed the Administrator confirmed Resident #64's DNR code status was deleted from the electronic record by mistake. The Administrator stated LPN #1 deleted the DNR order instead of a medication. The Administrator confirmed this was not found until the SA discovered it and reported the finding to them on 1/29/2020. The Administrator reported the facility ran a report of discontinued orders and found that LPN #1 discontinued the DNR order for Resident #64 on 12/1/2019. A medication order should have been discontinued instead of Resident #64's code status.	F 867			

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NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 530 HALL ST WIGGINS, MS 39577		
(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 867	Continued From page 74 An interview, on 1/31/2020 at 11:45 AM, with LPN #1, revealed she clicked on the wrong thing in the computer. LPN #1 confirmed she clicked on DNR instead of a medication she was trying to delete. LPN #1 did not realize the mistake until LPN #4 revealed it to her. On 1/29/2020 at 12:16 PM, an interview with Licensed Practical Nurse (LPN) #5 revealed she didn't know what happened with Resident #64's code status being incorrect. LPN #5 stated she missed it. Resident #64's DNR code status was deleted on the Electronic Record. During an interview, on 1/28/2020 at 4:20 PM, LPN #6 revealed the nurses were trained to find the resident's code status on their Quick Reference Sheet, on the MARs, the bright red sheet at the nurse's station and crash cart. LPN #6 also said the ADON updates them monthly and with new admits or changes in the resident's code status. During an interview with LPN #7, on 1/28/2020 at 4:45 PM, she revealed the nurses are trained to find the resident's code status on top of the MARs, Quick Reference Sheet, the red sheet at the nurses' station and crash cart. LPN #7 also said she thought the ADON updated them. LPN #7 stated the nurses write changes on their report sheet and turn it in at the end of the shift. An interview, on 01/29/2020 at 12:22 PM, revealed the ADON said she was responsible for checking the resident's code status and making sure there's a written order in the Electronic Record and on the MAR. The ADON also confirmed the facility was not aware of the nurse	F 867			

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F 867	Continued From page 75 deleting the resident's Code status until the SA discovered it. The ADON also stated if Resident #31 and Resident #64 conditions would have changed, both residents potentially could have had Cardiopulmonary Resuscitation (CPR) done, which could possibly cause pain from broken ribs and or resident being placed on a ventilator. This is the facility's accepted Immediate Jeopardy Removal Plan: Summary of events: The State Agency notified Azalea Gardens Nursing Center on January 29th, 2020 at 12:05 P.M. of the immediate jeopardy and substandard quality of care for Residents #74, #31, and #64. The Facility failed to honor Resident #74's advance directive for a do not resuscitate (DNR) code status, failed to honor the Resident's Rights for Advance Directive, failed to follow the care plan for a DNR code status and failed to prevent a potential negative outcome by initiating Cardiopulmonary Resuscitation (CPR). Resident #74 was found pulseless on October 6th, 2019 at 7:28 PM by RN #1 who initiated Cardiopulmonary Resuscitation (CPR) for a total of five minutes. CPR was discontinued when emergency services arrived and notified RN #1 of Resident#74's DNR code status. RN #1 failed to follow the policy and procedures in place to identify Resident #74's code status. The State Agency notified the facility on January 28th, 2020 at 3:30 PM that Resident #31's code status was documented incorrectly on the Report Sheet and Resident #64's code status was not in the Electronic Health Record, according to their wishes which could have likely caused harm for Residents #31 and #64. The facility failed to follow policy and procedure to	F 867			

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F 867	Continued From page 76 identify the correct code status for Residents #74, #31, and #64. Facility action plan: 1. The Director of Nursing (DON) conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with Registered Nurse (RN) #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. On November 27th, 2019 Care Plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. On December 24th, 2019 at 1:30 PM the Director of Nursing in serviced all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. On January 29th and 30th, 2020 the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. On November 27, 2019 the Assistant Director of Nursing (ADON) reviewed all code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse events. A total of 77 records were reviewed with no discrepancies. The findings were 55 DNR and 22 full code status. 6. On January 29th, 2020 at 12:05PM, the State Agency identified concerns for code status on	F 867			

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F 867	Continued From page 77 Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. Care Plan Nurse found that Resident #64's order had been discontinued by Licensed Practical Nurse (LPN) #1 and the order was reentered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status. 8. The Quality Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified	F 867			

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F 867	Continued From page 78 Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. No staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member. The facility alleges the immediate jeopardy was removed on January 30, 2020. On 1/31/2020, the State Agency (SA) validated the facility's Removal Plan by staff interviews, record reviews, review of in-service sign-in sheets, and review of documents across all disciplines. The SA verified the facility had implemented the following measures to remove the IJ:	F 867			

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F 867	Continued From page 79 1. The SA validated through record review of the sign-in sheets and interview with the Director of Nursing (DON) that the facility conducted an in service on October 8th, 2019 at 2:30 PM to include return demonstration of a mock code drill, communication of code status policy and review of CPR policy with RN #1 and RN #2. No concerns were identified. No disciplinary action for RN #1 or RN #2 occurred. 2. The SA validated through record review of the in-service sign-in sheets and interview with the Care Plan Nurse that on November 27th, 2019 Care plan Nurse conducted in services from 7:30 AM to 5:30 PM on initiating CPR and how to identify resident code status. 3. The SA validated through record review of the sign-in sheets and interview with the DON that the facility conducted an in-service on December 24th, 2019 at 1:30 PM, by the Director of Nursing, to all licensed nurses on honoring residents' rights, the right to choose code status and CPR policies. 4. The SA validated through record review of the in-service sign-in sheets and interview with the facility owner that on January 29th and 30th, 2020, the owner of the facility conducted an in service starting at 1:30 PM on January 29, 2020 and ending at 3 PM on January 30th, 2020 to discuss the advance directive protocol for determining code status, location of code status, policy and procedure related to communication of code status with all licensed nurses. 5. The SA validated by interview of the ADON that on November 27, 2019 the ADON reviewed all code status records in each resident's paper chart and compared all resident's electronic health record to ensure all code status orders were being followed to prevent any adverse	F 867			

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F 867	Continued From page 80 events. A total of 77 records were reviewed with no discrepancies. The findings were 55 DNR and 22 full code status. 6. The SA validated by record review and staff interviews, on January 29th, 2020 at 12:05 PM, the SA identified concerns for code status on Resident #64 which was not in the Electronic Health Record orders and Resident #31 which was incorrectly listed on the Report Sheet. The Care Plan Nurse found that Resident #64's order had been discontinued by LPN #1 and the order was re-entered into the Electronic Record. Resident #31's order was recorded incorrectly on the Report Sheet. The Report Sheets with code status were immediately removed from the nursing station. The audit completed on January 29, 2020 by the Care Plan Nurse, ADON and Restorative Nurse found all paper charts and Electronic Health Records were 100% in compliance. to prevent any future adverse events or outcomes. 7. The SA validated by interviews the Quality Assurance team met on December 13th, 2019 at 8 A.M. to discuss the policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist (ICP), Quality Assurance (QA), Licensed Social Worker, Certified Recreational Therapist, Medical Records Nurse, Certified Dietary Manager, ADON, and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on honoring Residents' Rights and the right to choose a code status. 8. The SA validated through interviews with the Facility Administrator and the DON the Quality	F 867			

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F 867	Continued From page 81 Assurance team met on January 29th, 2020 at 1:40 P.M. to discuss the negative outcome and failure to implement and follow policy and procedure related to the code status of each resident. The Quality Assurance team that met was the Director of Nursing, Medical Director, Administrator, Infection Control Preventionist, Quality Assurance, Owner of facility, Nurse Practitioner Clinician, Certified Recreational Therapist, Certified Dietary Manager, Dietitian, Assistant Director of Nursing, Licensed Social Worker, Restorative Nurse, Minimum Data Set Nurse, Clinical Liaison Nurse, Medical Records Nurse and Care Plan Nurse. A plan of action was implemented at this time to ensure that all licensed nurses were in serviced on the advance directive protocol for determining code status. All resident charts were audited to ensure no discrepancies between the electronic health record, orders, and the paper chart. The Quality Assurance team reviewed the audit and found the charts were 100% compliant. The Policies of Communication of Code Status and Cardiopulmonary Resuscitation Procedure policies was reviewed, and no revisions were required. A Quality Assurance Performance Improvement plan was discussed, developed and implemented. The Communication of Code Status Policy states that the nurse who notes the physician order is responsible for communicating the directions in all relevant sections of the medical record. The SA validated through interviews with the Administrator and the DON that no staff will be allowed to work at the facility prior to receiving in service training on facility policy and procedure on identifying code status with understanding expressed by staff member.	F 867			

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F 867	Continued From page 82 The SA validated that all corrective actions to remove the IJ had been completed as of 1/30/2020, and the IJ removed on 1/31/2020, prior to exit.			F 867			

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NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 530 HALL ST WIGGINS, MS 39577		
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{K 000}	INITIAL COMMENTS	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{E 000}	Initial Comments			{E 000}			

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