STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065321	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arvada Care and Rehabilitation Center	6121 W 60th Ave Arvada, CO 80003

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on record review and interviews, the facility failed to ensure each resident had the right to formulate an advanced directive for one (#1) of three residents reviewed for advanced directives out of 10 sample residents. Upon Resident #1's admission to the facility on [DATE], a licensed practical nurse (LPN) #3 interviewed Resident #1 and filled out the advanced directive paper form with the necessary information indicating the resident chose to be a DNR (do not resuscitate) status. LPN #1 did not record the resident's DNR status in Resident #1's electronic medical records (EMR) as he was required to do. On [DATE] the medical provider discussed the decision to be a DNR status with Resident #1 and her family. The nurse practitioner (NP) signed the advanced directives paper form and returned the form to the nurse's station where the forms were kept for the facility staff to follow-up. On [DATE] (seven days after the resident was admitted to the facility) Resident #1 had a cardiac arrest (a medical emergency where the heart suddenly stops beating, preventing blood from flowing to the brain and other vital organs) in her room. On [DATE] the nursing staff could not locate the advanced directives form that designated Resident #1's wished to be a DNR status. The nursing staff called the emergency medical technicians (EMT). When the EMTs entered the facility, the facility nursing staff told the EMTs that the resident's directives were to receive cardiopulmonary resuscitation (CPR). The EMTs performed CPR, inserted an intubation tube down Resident #1's trachea (windpipe) and transported the resident to a local hospital. The local hospital documented Resident #1 had a cardiac arrest and was a DNR status but an intubation had occurred in the field. According to Resident #1's family member, the hospital physician asked the family, due to the fact that Resident #1 had already been intubated, if the family would like to see if Resident #1 would recover over the next 24 to 48 hours. The resident's family agreed, however, after 24 hours the family felt Resident #1 had suffered from being intubated and requested the hospital remove the intubation tube. Resident #1 passed away within an hour after the intubation tube was removed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Actual harm Residents Affected - Few	Due to the facility's failure to ensure Resident #1's advanced directives wish to be a DNR status was communicated and documented appropriately, Resident #1 was provided CPR and intubated following a cardiac arrest, which resulted in unnecessary suffering for the resident and her family prior to her death one day after the event. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on [DATE] to [DATE]. Resulting in the deficiency being cited as past noncompliance with a correction date of [DATE]. I. Incident on [DATE] On [DATE] (seven days after the resident was admitted to the facility) Resident #1 had a cardiac arrest (a medical emergency where the heart suddenly stops beating, preventing blood from flowing to the brain and other vital organs) in her room. On [DATE] the nursing staff could not locate the advanced directives form that designated Resident #1's wished to be a DNR status. The nursing staff called the emergency medical technicians (EMT). When the EMTs entered the facility, the facility nursing staff told the EMTs that the resident's directives were to receive cardiopulmonary resuscitation (CPR). The EMTs performed CPR, inserted an intubation tube down Resident #1's trachea (windpipe) and transported the resident to a local hospital. The local hospital documented Resident #1 had a cardiac arrest and was a DNR status but an intubation had occurred in the field. According to Resident #1's family member, the hospital physician asked the family, due to the fact that Resident #1 had already been intubated, if the family would like to see if Resident #1 would recover over the next 24 to 48 hours. The resident's family agreed, however, after 24 hours the family felt Resident #1 had suffered from being intubated and requested the hospital remove the intubation tube. Resident #1 passed away within an hour after the intubation tube was removed. Due to the facility's failure to ensure Resident #1's advanced directives wish to be a DNR status was communicated and documented appropriately, Resident #1 was provided CPR and intubated following a cardiac arrest, which resulted in unnecessary suffering for the resident and her family prior to her death one day after the event. Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on [DATE] to [DATE]. Resulting in the deficiency being cited as past noncompliance with a correction date of [DATE]. II. Facility's plan of correction The corrective action plan implemented by the facility in response to Resident #1's advanced directives failure on [DATE] was provided by the corporate consultant (CC) on [DATE] at 1:12 p.m. The plan read: (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	[DATE] A. Corrective action: Resident #1's (advanced directive) form was uploaded into the resident's EMR to reflect the correct core status. B. Identification of others: All residents have the potential of being affected by said deficient practice. No additional concerns were identified. C. Systemic changes: The DON/Designee will provide education to licensed nurses regarding completely filling out the advanced directives (specific name) form. Updating orders in the electronic records, the new advanced directives form books, and what to do with the advance directive forms while awaiting a medical director signature. The DON/Designee will educate agency staff prior to the start of their shift on the advanced directive process. The DON/Designee will educate (the) Social Service Director (SSD) on reviewing the advanced directive form with all care conferences or with a change in CPR status of a resident. At minimum the advanced directive form will be reviewed every 90 days or every 30 days if a verbal consent was given. The advanced directive form will be updated with the date and signature of who is verifying the information. SSD will then place the updated form back in the advanced directive binder. The DON/Designee will educate (the) medical records (staff) on reviewing the advanced directive forms prior to it being uploaded into the resident's EMR (electronic medical record). And when obtaining an advanced directive form to scan into the system, a temporary copy will be placed in the advanced directive book until medical records (staff) are able to put the original back in the advanced directive binder. D. Monitoring: The DON or designee will audit five residents weekly times 12 weeks or until substantial compliance is met. Results will be reviewed in QAPI (quality assurance performance improvement meeting) until substantial compliance has been met. Update [DATE] - QAPI was reviewed [DATE] and [DATE] and will be reviewed today in QAPI [DATE]. E. Date of completion: [DATE] Interviews and record review during the investigation revealed corrective actions to identify the resident and other residents who had the potential to be affected by the deficient practice, systemic changes to prevent its recurrence, and monitoring to ensure sustained corrections were in place. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	III. Facility policy and procedure The Emergency Procedures Cardiopulmonary Resuscitation (CPR) policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 11:30 a.m. The policy read in pertinent part: It is the policy of this facility to provide basic life support (BLS), including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel in the absence of advance directives or a 'Do Not Resuscitate (DNR)' order. Cardiopulmonary Resuscitation (CPR) refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased. Do Not Resuscitate (DNR) Orders refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. The Advanced Directives policy, reviewed [DATE], was provided by the NHA via email on [DATE] at 1:43 p. m. The policy read in pertinent part, It is the intent of this policy to illustrate the reconciliation of advance directives in the facility. Prior to admission, the resident or legal representative will be informed of their right to have or refuse a CPR directive. The resident or responsible party will provide a copy of any/all advance directives for the residents chart. The resident or responsible party will be asked to fill out and sign a Colorado MOST (Medical Orders for Scope of Treatment) form upon admission indicating their wishes in the event of a health emergency. The resident and/or legal representative shall sign and date the form acknowledging that the options were reviewed and understood. Such documentation shall be maintained in each resident's record. The form will also be signed by the resident's medical provider. The facility will have a system for staff to identify the code status of each resident. Any resident who does not have a signed order or advance directive will be treated as a full code until the order is signed by the resident/responsible party and the provider. IV. Resident #1 A. Resident status (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	Resident #1, age 70, was admitted on [DATE] and discharged to the hospital on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), emphysema, malignant neoplasm of the colon (colon cancer), pressure ulcer of the sacral region, gastroesophageal reflux disease (GERD) and dysphagia (difficulty swallowing). The [DATE] minimum data set (MDS) assessment revealed the resident was moderately impaired for daily decision making skills. The resident did not have any behaviors and did not reject care from staff. She required partial assistance with upper body dressing, and hygiene. She required set-up or clean-up assistance with eating, and oral hygiene. She was dependent on staff for lower body dressing, putting on and off footwear, and toileting. B. Family interview The resident's family member was interviewed on [DATE] at 8:46 a.m. The family member said the facility staff called him at home on [DATE] and told him Resident #1 had an emergency health event. The family member said when he arrived at the facility, several EMTs were in Resident #1's room doing something to her. He said he did not know what the EMTs were doing. He said, at the hospital, he was told that his family member was intubated. He said I was shocked. She (Resident #1) never wanted to have CPR or have a tube shoved down her throat. She and I both told the facility she wanted to be DNR and even signed the paperwork. She wanted to go home and die with hospice. The family member said on [DATE] the doctor at the hospital asked him, since an intubation tube was already placed, if he would he like to wait 24 to 48 hours to see if Resident #1 responded. The family member said he told the hospital doctor yes. He said After 24 hours I saw she was suffering and I asked the hospital to take the tube out. She died about one hour after that. I just could not let her suffer. C. Record review The Colorado MOST form was signed by Resident #1's family member and LPN #1 on [DATE]. On [DATE] the MOST form was also signed by the facility NP who said the form was discussed with both Resident #1 and her family member (see LPN #1 and NP interviews below). Review of the MOST form revealed Resident #1 agreed to the box marked No CPR, do not attempt resuscitation, and do not transfer to the hospital for life-sustaining treatment. The form further revealed the resident wanted no artificial nutrition by tube, and the decisions were discussed with the medical durable power of attorney (MPOA). The form documented the healthcare facility shall comply with an adult's properly executed MOST form. The form documented HIPAA (Health Insurance Portability and Accountability Act) permitted disclosure of this information to other healthcare professionals as necessary. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	The nursing progress note on [DATE] at 2:30 p.m. revealed, registered nurse (RN) #1 and a CNA noticed Resident #1 looking up at the television (TV) but she was not responsive. The ambulance arrived and did CPR as per the chart. All paperwork was given to the paramedics who took Resident #1 to the hospital. The hospital records dated [DATE] documented that on [DATE] Resident #1 had an unwitnessed cardiac arrest, with an unknown amount of time down. CPR was initiated, and Resident #1 was intubated prior to arrival (at the hospital) even though she was a DNR. V. Staff interviews LPN #1 was interviewed on [DATE] at 3:30 p.m. LPN #1 said she went into Resident #1's room on [DATE] to give medications to her. She said Resident #1 was looking at the television but did not respond to LPN #1 when she said her name. LPN #1 said she contacted RN #1 and the former director of nursing (FDON) to help. LPN #1 said none of the three nursing staff, herself along with RN #1 and the FDON, could find Resident #1's MOST form to check her code status and it was not in the EMR either. She said she was trained when a person did not have an advanced directive, CPR must be performed. She said no documentation was found for Resident #1's advanced directive wishes and that was why the staff told the EMTs to perform CPR. RN #1 was interviewed on [DATE] at 4:43 p.m. RN #1 said the medical records director (MRD) was responsible for uploading the MOST forms into the EMRs, but the MRD was on vacation when Resident #1 was admitted on [DATE] and the paperwork was not put into the EMR. RN #1 said she, the FDON and LPN #1 looked around the nurses station for Resident #1's MOST form but the three nursing staff could not find it. RN#1 said the social service director (SSD) tried to help locate the MOST form but he could not find it either. RN #1 said she called the paramedics, who arrived quickly, and the facility staff told the paramedics the resident was to have CPR. She said the paramedics asked the staff repeatedly if they were sure Resident #1 wanted CPR. RN #1 said the staff told the paramedics yes to do CPR. RN #1 said the paramedics performed CPR and intubated Resident #1 while they were in the facility. RN #1 said after Resident #1 was taken to the hospital by the paramedics, she found the MOST form in the drawer at the nurse's station. RN #1 said on the form everything was properly signed by the family and the NP. RN #1 said the situation with Resident #1 was devastating to her. She said she called the facility's corporate liaison about the situation. RN #1 said the corporate consultant (CC) came in the next day and began to fix the situation. LPN #3 was interviewed on [DATE] at 10:48 a.m. LPN #3 said he was the one who went over the MOST form with Resident #1 and her family member. LPN #3 said the staff signature on the form was his. LPN #3 said Resident #1 was a DNR status per her request. LPN #3 said he did not remember where he put the advanced directive form after it was signed. LPN #3 said he may have passed it off on the night shift nurse to enter into the EMR because staff were supposed to enter the advanced directive information into the computer after it was filled out. LPN #3 said after the incident on [DATE] he received a private education from the FDON about the MOST forms, as well as group education about advanced directives from the FDON and the CC. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	The SSD was interviewed on [DATE] at 11:30 a.m. The SSD said when a person was admitted to the facility the admitting nurse was to get the resident's signature, or the MPOA to sign the MOST form, and then the medical provider signed the advanced directives also. The SSD said when Resident #1 admitted , the MRD was on vacation and he did not know who was to cover for the MRD to make sure the MOST forms were uploaded into the system. The SSD said the management team discussed the situation after the incident when Resident #1 should have been a DNR and not a full code. The SSD said the advanced directives were not uploaded into the system until after the incident with Resident #1. The SSD said the resident was not at the facility long enough to do a brief interview for mental status (BIMS) but a BCAT (brief cognitive assessment tool) was done with the resident. The SSD said the form revealed the resident had mild dementia, was able to be understood by others, was independent with directions, had the ability to express ideas and she was understood. The NP was interviewed on [DATE] at 12:05 p.m. The NP said she met with Resident #1 and her family member and the three of them discussed the advanced directive wishes for Resident #1. The NP said both the resident and her family member wanted the resident's status to be a DNR. The NP said she signed the form for the DNR status. The NP said Resident #1 told her she had a care conference in a week and she wanted to go home and be on hospice because her health had not improved. The NP said she put the signed form in a box at the nurse's station marked for the physicians. The NP said she did not have access to put the advanced directive information into the facility's EMRs. The MRD was interviewed on [DATE] at 12:15 p.m. The MRD said she went on vacation the week Resident #1 admitted . The MRD said while she was on vacation, the FDON was assigned to check on the MOST forms for all newly admitted residents and make sure the physicians signed the forms. The MRD said she was the one who usually checked that the MOST information was entered into the EMRs. The MRD said she made copies of the MOST forms and put them in a book at each nurse's station with all of the resident'' MOST forms. The CC was interviewed on [DATE] at 11:00 a.m. The CC said she received a phone call from the FDON on [DATE] to inform her Resident #1 went to the hospital and that the FDON was unaware Resident #1 was a DNR status. She said the FDON told her that CPR had been administered to the resident. The CC said LPN #3, who signed the form with Resident #1, did not enter Resident #1's DNR status information into the EMR as he should have done. The CC said LPN #3 signed the MOST form and put it in the drawer at the nurse's station and that was where the form was found later that day ([DATE]). The CC was interviewed again on [DATE] at 9:30 a.m. The CC said she began an investigation into the incident with Resident #1 on [DATE]. She said on [DATE] she began an education with all of the nursing staff about code statuses. The CC said any staff who were not in the facility that day received the training over the phone. The CC said she did an audit to make sure all of the residents in the facility had their MOST forms completed and entered into the EMRs. The CC said she also made sure each nurse's station had a green binder with each resident's MOST form in alphabetical order. She said no additional concerns were found. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	The CC said LPN #3 was provided education from the FDON. The CC said LPN #3 put the signed MOST form for Resident #1 into a drawer at the nurse's station and did not enter it into the EMR as he was required to do, nor did LPN #3 put the form into the MOST book. The CC said on [DATE] she provided a mock code with the staff who went through a simulation of how to find a resident's code status. The NHA was interviewed on [DATE] at 2:15 p.m. The NHA said the incident with Resident #1 was reviewed for three months in the facility QAPI meeting. The NHA said all resident's MOST forms had been followed correctly since the CC began the plan of correction implemented on [DATE]. The NHA said he believed the situation was remedied and all residents would have their MOST forms honored.