STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Aurora Care Center	310 Banbury Road North Aurora, IL 60542

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30973 Based on interview and record review the facility failed to keep a resident free from neglect when they failed to initiate cardiopulmonary resuscitation CPR). This applies to 1 of 3 residents (R1) reviewed for interventions at time of death in a sample of 100. Findings include: R1's Admission Record dated [DATE] documents R1 as an [AGE] year old with diagnoses to include Bipolar Disorder, Dementia, and Schizoaffective Disorder. On [DATE], R1's paper chart included a green Practitioner Order for Life-Sustaining Treatment (POLST) form dated [DATE], and signed by V14 (R1's Physician and facility Medical Director). The POLST included R1's signature and in Box A, the option for Attempt Resuscitation/CPR (Selecting CPR means Full Treatment .) was checked. The Reporting Officer statement from the [DATE], local Police Department's preliminary Case Report Summary showed .On [DATE] at 18:57 [6:57 PM] .responded .for deceased patient at [facility address]. Due to some uncertainty, dispatch clarified that this was not an in-progress emergency, rather the patient, [R1] . had been deceased for some time. This document shows the timeline obtained by the officers during interviews conducted with the witnesses on [DATE] as follows: R1 was discovered deceased between 5:, d+[DATE]:20 PM by V6 (Nursing Assistant) who then alerted V5 (Nurse). V5 stated to the officer she then spent the time between discovering R1 was deceased up to the time 911 was contacted at 6:57 PM attempting to locate R1's DNR paperwork, contacting hospice, and the state guardian. This report shows a hospital physician provided a time of death to the paramedics as 7:20 PM. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:10 PM V5 stated she was assigned as R1's nurse on [DATE] between 7 AM-7 PM. V5 stated she was instructed at the beginning of her shift that R1 was on hospice and had a Do Not Resuscitate (DNR [do not attempt CPR]) order. V5 stated between 5:,d+[DATE]pm a Nursing Assistant (V6) reported to her R1 was not breathing. V5 assessed R1 and after taking vitals and confirming R1 was not breathing she went to find R1's chart and did not start CPR because she was unsure of her advanced directives. V5 stated, while contacting hospice to clarify R1's advanced directives, I left (R1) with the workers in the back .I was in the nurse's station until I got a call back (from hospice). I then had another resident with an issue, so I handled that .I thought V2 (Director of Nursing) was with (R1) .Nobody is administering CPR and we are calling hospice, so I assumed she was a DNR. Later, I was told there was a DNR in process but not complete. Then I called the paramedics, 911, and assumed the people in the back initiated CPR . On [DATE] at 12:47 PM V3 (Nurse) stated at around 7 PM she saw V5 in the hallway. and she asked for help stating, it is an emergency. V3 stated she ran down the hallway and asked what is going on, and V5 responded, Apparently we were supposed to start CPR two hours ago, and that V5 was instructed to call 911. V3 stated CPR was not started until the paramedics arrived. On [DATE] at 2:36 PM V6 (Nursing Assistant) stated he found R1 non-responsive between 5:,d+[DATE]:20 PM and notified V5. V6 confirmed he did not perform CPR, stating V5 did not give him instructions to perform CPR. V5 stated he was instructed to perform postmortem care for R1 which he did and then about an hour later the paramedics arrived. On [DATE], at 12:05 PM, V2 (Director of Nursing) stated R1 was a full code in our chart. V2 stated R1 expired, and CPR was not performed. V2 stated If a full code, CPR should have been done. V2 re-iterated if there is no DNR, you initiate CPR. On [DATE] 6:57 PM V22 (Deputy Coroner) stated we were going to do an autopsy but decided not to after reviewing her comorbidities and speaking with V10 (R1's Guardian) and found out a DNR was in process but apparently not valid yet because the physician information and signature were not completed. V22 stated, My concern is nobody started CPR. That is basic nursing. Without a valid DNR order she should have been provided emergency interventions and CPR. I am not sure what they were thinking. I understand there was some confusion but without a valid DNR she is a full code. The facility Abuse Prevention Program policy dated [DATE] documents the facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property and exploitation. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30973 Based on observation, interview and record review the facility failed to implement their abuse policy when they failed to remove a staff from resident contact during an active neglect investigation, submit a timely final investigative report to the state agency, and formulate a conclusion after completion of the investigation. This applies to 1 of 3 residents (R1) reviewed for neglectful care in a sample of 100. Findings include: The facility Abuse Prevention Program policy dated [DATE] documents the facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property and exploitation. This policy documents the facility will take steps to prevent mistreatment, exploitation, neglect and abuse of residents and misappropriation of property while the investigation is underway, including any employ who has been accused of abuse or neglect will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator. The policy shows the summary, conclusions and results of the investigation will be recorded on a final written incident report which is to be submitted to the state agency within five working days of the occurrence. The Reporting Officer statement from the [DATE], local Police Department's preliminary Case Report Summary showed .On [DATE] at 18:57 [6:57 PM] .responded .for deceased patient at [facility address]. Due to some uncertainty, dispatch clarified that this was not an in-progress emergency, rather the patient, [R1] . had been deceased for some time. This document shows the timeline obtained by the officers during interviews conducted with the witnesses on [DATE] as follows: R1 was discovered deceased between 5:, d+[DATE]:20 PM by V6 (Nursing Assistant) who then alerted V5 (Nurse). V5 stated to the officer she then spent the time between discovering R1 was deceased up to the time 911 was contacted at 6:57 PM attempting to locate R1's DNR paperwork, contacting hospice, and the state guardian. This report shows a hospital physician provided a time of death to the paramedics as 7:20 PM. On [DATE] between 10 AM- 3 PM, V5 was observed working as a floor nurse, administering medications and caring for residents. On [DATE] at 2:13 PM V1 (Administrator) stated she is still investigating the circumstances surrounding the incident of [DATE] when V5 did not implement CPR when she found R1 expired. This final document was requested of V26 (Regional Director of Operations) at 11:20 AM on [DATE] and not received. The undated facility final investigative report of R1's death investigation was provided on [DATE] at 3:10 PM. This report was not submitted to the state agency as of [DATE] at 3:41 PM and does not document a final investigative summary. On [DATE] at 1:32 PM when asked about V5's presence at the facility, V2 (Director of Nursing) stated I called the agency to get her educated and they did do that. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:20 AM V26 (Regional Director of Operations) stated, The nurse should have been off during an active investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30973 Based on observation, interview and record review, the facility failed to initiate CPR (Cardiopulmonary Resuscitation) for a resident (R1) with full code status (attempt CPR). The facility also failed to have a system in place to ensure that Advance Directives are completed timely and available to direct care staff. These failures resulted in R1 not receiving CPR and expiring at the facility. These failures have the potential to affect all residents residing in the facility. The [DATE], Facility Data Sheet showed 96 residents reside at the facility. These failures resulted in Immediate Jeopardy. The Immediate Jeopardy was noted to begin on [DATE], when R1 was found not breathing and no CPR was initiated. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE], at 9:50 AM. Findings include: 1. R1's Admission Record dated [DATE] documents R1 as an [AGE] year-old with diagnoses that include bipolar disorder, dementia, and schizoaffective disorder. On [DATE], R1's paper chart included a green Practitioner Order for Life-Sustaining Treatment (POLST) form dated [DATE], and signed by V14 (R1's Physician and facility Medical Director). The POLST included R1's signature and in Box A, the option for Attempt Resuscitation/CPR (Selecting CPR means Full Treatment .) was checked. R1's Clinical Physician Order Report dated [DATE] shows an order dated [DATE] for R1 to be a full code (attempt CPR) but this order was discontinued on [DATE]. R1's Order Recap Report ,d+[DATE]-[DATE] does not show a current order for R1's code status. R1's Electronic Medical Record (EMR) shows a Progress Note dated [DATE] documenting V14 (Medical Director) provided an order for a hospice evaluation due to R1's refusal to eat and failure to thrive. R1's Hospice Telephone Verbal Order form dated [DATE] shows R1 was admitted to hospice with a primary diagnosis of dementia on this date. There is no indication of a code status on this document. R1's EMR Progress Note completed by V5 (Nurse) on [DATE] from 8:21 PM showed CNA (Certified Nursing Assistant) has reported to the writer about or around maybe later 5:20 PM that the resident has passed away .No vital and no pulse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 12:10 PM V5 (Nurse) stated she was assigned as R1's nurse on [DATE] between 7 AM- 7 PM. V5 stated she was instructed at the beginning of her shift that R1 was on hospice and had a Do Not Resuscitate (DNR [do not attempt CPR]) order. V5 stated on [DATE], R1 was acting as usual, stayed in bed and ate minimally. V5 stated she works many places as an agency nurse and is not sure what the process is at the facility to verify advanced directives. V5 stated around 4 PM, a nurse from hospice (V9) came into the facility and she and V9 went into R1's room together. V5 stated V9 informed her that R1 was beginning to transition. V5 stated around 5 PM, R1 was unchanged, and then sometime between 5:,d+[DATE]pm, a Nursing Assistant (V6) reported to her R1 was no longer breathing. V5 stated she assessed R1 and after taking vitals and confirming R1 was not breathing, she went to find R1's chart and notified V2 (Director of Nursing) that R1 had passed. V5 confirmed she did not notify V2 that she was unable to verify R1's code status and she did not initiate CPR. V5 stated when she entered the room, V1 (Administrator) was present and instructed her to call hospice to clarify her advanced directives, which she did. V5 stated after speaking with V8 (Hospice Nurse), he told V5 he would call her back. V5 stated, I left [R1] with the workers in the back. I was in charge of the patient but [V1] was in charge of me. I waited in the nurse's station as I was instructed to do. I was in the nurse's station until I got a call back. I then had another resident with an issue, so I handled that .I thought [V2 (Director of Nursing)] was with [R1] .Nobody is administering CPR and we are calling hospice, so I assumed she was a DNR. Later, I was told there was a DNR in process but it was not complete. Then I called the paramedics, 911, and assumed the people in the back initiated CPR. I did notify the people in the back that she was a full code. We all came back to the room; paramedics were back there then and were working on her when I got back to the room. V5 confirmed that at the time she discovered R1 had no vital signs, she was still unsure of R1's advanced directives because she was unable to find the chart where the POLST form is supposed to be located. On [DATE] at 7:47 AM, V4 (Nurse) stated he overheard a Nursing Assistant report to V5 that R1 doesn't look good. V5 requested V4's assistance with obtaining a blood pressure cuff and pulse oximeter which V4 stated he provided to V5, then went to attend to another resident. V4 stated at some point after this interaction he took a call from an unknown hospice nurse who reported to V4 that he was in the process of changing R1's full code status to a DNR. V4 stated this unknown hospice nurse was frustrated as to why the POLST form had not been completed. V4 could not indicate when he became aware that R1 had passed and was a full code. V4 stated he did not perform CPR at any time during this incident. On [DATE] at 12:47 PM, V3 (Nurse) stated that around 7 PM on [DATE], she saw V5 in the hallway and she asked for help, stating it is an emergency. V3 stated she ran down the hallway and asked what was going on, and V5 responded, Apparently we were supposed to start CPR two hours ago, and that V5 was instructed to call 911. V3 stated CPR was not started until the paramedics arrived. On [DATE] at 2:36 PM, V6 (Nursing Assistant) stated he found R1 non-responsive between 5:,d+[DATE]:20 PM and notified V5. V6 confirmed he did not perform CPR, stating V5 did not give him instructions to perform CPR. V5 stated he was instructed to perform postmortem care for R1, which he did, and completed care with the assistance of V7 (Nursing Assistant). V6 stated about an hour later, the paramedics arrived. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Reporting Officer statement from the [DATE], local Police Department's preliminary Case Report Summary showed .On [DATE] at 18:57 [6:57 PM] .responded .for deceased patient at [facility address]. Due to some uncertainty, dispatch clarified that this was not an in-progress emergency, rather the patient, [R1] . had been deceased for some time. This document shows the timeline obtained by the officers during interviews conducted with the witnesses on [DATE] as follows: R1 was discovered deceased between 5:, d+[DATE]:20 PM by V6 (Nursing Assistant), who then alerted V5 (Nurse). V5 stated to the officer she then spent the time between discovering R1 was deceased up to the time 911 was contacted at 6:57 PM attempting to locate R1's DNR paperwork, contacting hospice, and the state guardian. V2's (Director of Nursing) interview identified her at the facility at approximately 6 PM to pay her respects then she left. V4 (Nurse) stated he became aware of the situation between ,d+[DATE]:30 PM after notification by V5, who had indicated she was in the process of contacting hospice. V8 (Hospice Nurse) reported to the officer that he spoke with V5 at approximately 6:25 PM and advised V5 to call 911 because no DNR was in place. V3's (Nurse) statement to the officer identified she was notified of R1's status at approximately 7 PM. This report shows a hospital physician provided a time of death to the paramedics as 7:20 PM. On [DATE], at 12:05 PM, V2 (Director of Nursing) stated V5 (Nurse) is an Agency nurse, and she works at the facility a lot. V2 stated V5 notified her that R1 had expired. V2 stated she asked her if hospice had been notified and she said yes. V2 stated CPR was not done. V2 stated that once a resident is admitted to hospice services, hospice takes over. V2 stated the facility still provides standard care. V2 stated if hospice says a resident is a full code, the resident is a full code, adding R1 was a full code in our chart. V2 stated R1 expired, and CPR was not performed, adding If a full code, CPR should have been done. V2 re-iterated if there is no DNR, you initiate CPR. On [DATE] at 9:45 AM, V10 (R1's State Guardian) confirmed she was aware of R1's decline and as of [DATE] had been communicating with hospice regarding advanced directives. V10 stated that on [DATE] at 2:05 AM, she received an email from V8 (Hospice Nurse) regarding R1's change in status and concerns that R1's advanced directives at that time showed R1 as a full code. V10 stated she then spoke with the hospice company again on [DATE] at 9:17 AM and reviewed the required process as a State Guardian to consider changing R1's code status. V10 stated the process includes an initial form with supporting documentation signed by two doctors. V10 stated once this information is received, a POLST form can be signed by her as a resident's guardian. V10 stated, I cannot change a resident's status without knowing their wishes. On [DATE] 6:57 PM, V22 (Deputy Coroner) stated an autopsy was planned but it was later decided not to after reviewing R1's comorbidities and speaking with V10 (R1's Guardian) and finding out a DNR was in process but apparently not valid yet because the physician information and signature were not completed. V22 stated, My concern is nobody started CPR. That is basic nursing. Without a valid DNR order she should have been provided emergency interventions and CPR. I am not sure what they were thinking. I understand there was some confusion but without a valid DNR, she is a full code. In section 2.1 Admission to Hospice Program under Article II: Services to be Provided by Hospice in the facility's Nursing Facility Hospice Services Agreement, it showed (c) Hospice shall notify Nursing Facility whether a resident is authorized for admission as a Patient and shall be responsible for obtaining all necessary admission forms, consents, and election statements from the Resident or, where applicable, the Resident's representative. The Article does not refer to hospice being responsible for obtaining a POLST form. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R1's hospice Informed Consents/Election of Benefits Form was stamped and signed by R1's State Guardian and hospice company on [DATE], and it does not mention the completion of a POLST form. R1's Circuit Court Letters of Office Guardianship of a Disabled Person dated [DATE] documents R1 as a disabled person totally without capacity per physician and therefore ordered a plenary guardian of person. 2. On [DATE] at 2:13 PM V1 (Administrator) stated advanced directives are initiated at admission. If a resident does not have a POLST in place upon admission, we implement the process and obtain one. POLST forms are obtained by a joint effort between nursing and social services. All residents should have a POLST form in their paper chart and a physician order indicating their code status in the Electronic Medical Record (EMR). A review of R5-R17, and R19's paper charts on [DATE], did not find a completed POLST form in their chart. The Admission Record shows R17 admitted to the facility on [DATE]. R17's Order Summary Report dated [DATE] did not include an order indicating code status. The Admission Record shows R10 admitted to the facility on [DATE]. R10's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. The Admission Record shows R16 admitted to the facility on [DATE]. R16's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. The Admission Record shows R5 admitted to the facility on [DATE]. R5's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. The Admission Record shows R9 admitted to the facility on [DATE]. R9's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. The Admission Record shows R11 admitted to the facility on [DATE]. R11's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. On [DATE] at 12:15 PM, V20 (Social Services) stated the last Social Service Director that was here would review the POLST forms. V20 stated, We have had a lot of 'hiccups' since transferring to PCC (Electronic Medical Records System) and I do not have access to fix it .We are running into hiccups when we compare the (paper) charts with PCC. It has been an ongoing issue, including the face sheet (Admission Record) not always being accurate . V20 stated V1 has requested access for Social Services approximately ,d+[DATE].5 months prior in order to correct issues identified with inconsistent information in PCC, and access has not been granted as of this date. On [DATE] at 1:20 PM, V21 (Social Service Director) stated she began employment at the facility [DATE]. When asked what her role is in the initiation of advanced directives, V21 responded with, I would think that I should be involved in advanced directives and code status initiation and changes. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:35 AM, V2 (Director of Nursing) stated the facility process for the completion of POLST forms is that V14 (Medical Director) comes in every Thursday, so if a POLST form needs to be signed, we let him know when he comes in. V2 stated Social Services will try to get POLST forms done as soon as possible and in an acceptable amount of time. V2 further stated that if it is an emergency, the facility will fax the POLST form to V14, but if not an emergency, it can be held until Thursdays. V2 stated that in early May, an audit of POLST forms was done and updated. On [DATE] at 1:05 PM, V1 (Administrator) stated that she was aware a recent audit was done by V2 and V25 (Assistant Director of Nursing) in May. V1 stated that physician orders are entered into the EMR by Nursing and Social Service does not have access to make changes. V2 confirmed inconsistent information related to advanced directives has been an ongoing issue at the facility since PCC was initiated last June. V1 stated she has asked the facility corporate office to give additional access to some staff and she has also requested the ability to scan documents into PCC. The Advanced Directive Policy dated [DATE] documents the following: The Patient Self Determination Act states that individuals have the right to make their own decisions, and to formulate advance directives to serve as decisions when the individual is incapacitated. It is the policy of this facility to honor resident's wishes as expressed in advanced directives regarding medically indicated treatments whenever possible. This facility shall take all steps necessary to comply with state and federal legislation relating to advance directives. Procedure: 1. At the time of admission each resident, POA (Power of Attorney), guardian or responsible party shall be given written information regarding resident rights and advance directive. At this time, each resident /responsible party will be requested to furnish this facility with copies of all existing advance directives. 2. The day of admission to this facility, the Social Service Designee, Administrator or designee at admission shall meet with the resident/responsible party to review existing advance directives. 3. After confirming the accuracy of provided documents with the resident/responsible party, the document will be sent for appropriate signatures. No order for No Code or DNR shall be effective until the Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form is signed by resident/responsible party and physician order is received and documented. 4. Any decision made by the resident shall be indicated in the chart in the manner easily understood by all staff. Advance directives specifying full code/Attempt Resuscitation/CPR, or the absence of determination shall be recorded as a Full Code. Those residents indicating Do Not Attempt Resuscitation/DNR shall be recorded as a DNR. Code status shall also be recorded on the resident's Physician Order Sheet. 6. In cases where a legal guardian has been appointed by the court, and the resident is without decisional making capabilities or a qualifying condition, the guardian must seek court authorization for consent for a DNR. Until this consent is obtained, the resident shall be considered without advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8. Any advance directive will be reviewed quarterly with the interdisciplinary team and the resident/responsible party. Advance directives may be reviewed more frequently as condition warrants. 9. Implementation of a code is as follows: i) Direct and Non-Direct care staff upon finding a resident non-responsive shall remain with that resident as is possible while signaling for assistance. ii) The nurse shall be summoned to respond, and upon review of chart documents determine code status. iii) The nurse shall evaluate the code status and notify appropriate staff for task assignment. If CPR is indicated only certified personnel shall administer CPR. iv) Activation of the Emergency Medical System shall be initiated, or the ambulance service notified. The physician shall also be notified to inform him/her of the resident condition. v) Upon completion of notifications and necessary paperwork, the nurse shall relieve those performing CPR. The appropriate certified staff will continue until the emergency medical team arrives and takes over. vi) The emergency medical team trained in advanced life support shall then assume charge of the situation. The nurse shall follow the direction on the emergency medical team, until transport of the resident out of the facility. 10. Once CPR is initiated in this facility, the staff trained in CPR shall continue until: i) The resident is revived. ii) The emergency medical team has arrived and assumed care iii) The physician gives an order to stop CPR The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: A. All staff were in-serviced on Advance Directive policy, Emergency Management policy, Change in Condition policy, and the location of binders made available at the nurses' station to direct care staff with all POLST/codes status for each resident. B. All agency were in-serviced on the Advance directive policy, Changes in Condition policy and the location of code status in binder. C. All staff were in-serviced on the process of how to get information of residents advance directives and code status. D. An audit of all residents POLST forms was conducted. For the residents with no current POLST the Social Service Director initiated the process for up to date POLST. (continued on next page)

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	14E306	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	E. Binders made available at the nurses' station to all staff with all POLST/codes status for each resident. Social Service will monitor and maintain the binders. F. A QA meeting was conducted [DATE] and the medical director was in agreeance with plan of correction. G. All agency staff will be in-serviced by the DON/Designee on code status/POLST/Change on condition upon hire. H. All facility staff will be in-serviced on code status/POLST/Change in condition by the DON/Designee upon hire, quarterly, and annually. I. Social Service Director/DON/Designee will review new resident's code status once weekly for 4 weeks to ensure POLST form is completed. J. Social Service Director/DON/Designee will review all code status/POLST forms once monthly for 3 months to ensure compliance. K. Social Service Director/Designee will review PCC code status and POLST binder once daily for 3 months, once weekly for 3 months and then quarterly thereafter. Results will be submitted and reviewed during QAPI meetings. L. Social Service Director/DON/Designee will review all residents changing to hospice to ensure code status/POLST in place once weekly for 3 months and then quarterly thereafter. M. Social service/Designee to audit both binders once weekly for 3 months and then quarterly thereafter.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30973 Based on observation, interview and record review the administrator failed to have a system in place to ensure that Advance Directives are completed timely and available to direct care staff. The facility also failed to coordinate advanced directives with hospice and guardian. The administrator failed to remove an employee being investigated for neglect during an active investigation and to summarize the findings of an investigative report. These failures have the potential to affect all residents residing in the facility. The [DATE], Facility Data Sheet showed 96 residents reside at the facility. Findings include: 1. On [DATE] at 2:13 PM V1 (Administrator) stated advanced directives are initiated at admission. If a resident does not have a POLST in place upon admission, we implement the process and obtain one. POLST forms are obtained by a joint effort between nursing and social services. All residents should have a POLST form in their paper chart and a physician order indicating their code status in the Electronic Medical Record (EMR). A review of R5-R17, and R19's paper charts on [DATE], did not find a completed POLST form in their chart. The Admission Record shows R17 admitted to the facility on [DATE]. R17's Order Summary Report dated [DATE] did not include an order indicating code status. The Admission Record shows R10 admitted to the facility on [DATE]. R10's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. The Admission Record shows R16 admitted to the facility on [DATE]. R16's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. The Admission Record shows R5 admitted to the facility on [DATE]. R5's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. The Admission Record shows R9 admitted to the facility on [DATE]. R9's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. The Admission Record shows R11 admitted to the facility on [DATE]. R11's Order Summary Report dated [DATE] found an order dated [DATE] for a full code. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:15 PM V20 (Social Services) stated the last Social Service Director that was here would review the POLST forms. V20 stated, We have had a lot of hiccups since transferring to PCC (Electronic Medical Records System) and I do not have access to fix it .We are running into hiccups when we compare the (paper) charts with PCC. It has been an ongoing issue, including the face sheet (Admission Record) not always being accurate . V20 stated V1 has requested access for Social Services approximately ,d+[DATE].5 months prior in order to correct issues identified with inconsistent information in PCC which has not been granted as of this date. On [DATE] at 1:20 PM V21 (Social Service Director) stated she began employment at the facility [DATE]. When asked what her role is in the initiation of advanced directives, V21 responded with, I would think that I should be involved in advanced directives and code status initiation and changes. On [DATE] at 11:35 AM V2 (Director of Nursing) stated the facility process for the completion of POLST forms is V14 (Medical Director) comes in every Thursday so if a POLST form needs to be signed we let him know when he comes in. V2 stated Social Services will try to get POLST forms done as soon as possible and in an acceptable amount of time. V2 further stated, if it is an emergency the facility will fax the POLST form to V14, but if not, an emergency it can be held until Thursday. V2 stated in early May an audit of POLST forms were done and updated. On [DATE] at 1:05 PM V1 (Administrator) stated, she was aware a recent audit was done by V2 and V25 (Assistant Director of Nursing) in May. V1 stated, physician orders are entered into the EMR by Nursing; Social Service does not have access to make changes. V2 confirmed inconsistent information related to advanced directives has been an ongoing issue at the facility since PCC was initiated last June. V1 stated she has asked the facility corporate office to give additional access to some staff and she has also requested the ability to scan documents into PCC. The Advanced Directive Policy dated [DATE] documents the following: The Patient Self Determination Act states that individuals have the right to make their own decisions, and to formulate advance directives to serve as decisions when the individual is incapacitated. It is the policy of this facility to honor resident's wishes as expressed in advanced directives regarding medically indicated treatments whenever possible. This facility shall take all steps necessary to comply with state and federal legislation relating to advance directives. Procedure: A. At the time of admission each resident, POA (Power of Attorney), guardian or responsible party shall be given written information regarding resident rights and advance directive. At this time, each resident /responsible party will be requested to furnish this facility with copies of all existing advance directives. B. The day of admission to this facility, the Social Service Designee, Administrator or designee at admission shall meet with the resident/responsible party to review existing advance directives. C. After confirming the accuracy of provided documents with the resident/responsible party, the document will be sent for appropriate signatures. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. Any advance directive will be reviewed quarterly with the interdisciplinary team and the resident/responsible party. Advance directives may be reviewed more frequently as condition warrants. 2. R1's Admission Record dated [DATE] documents R1 as an [AGE] year-old with diagnoses to include Bipolar Disorder, Dementia, and Schizoaffective Disorder. R1's Circuit Court Letters of Office Guardianship of a Disabled Person dated [DATE] documents R1 as a disabled person totally without capacity per physician and therefore ordered a plenary guardian of person. On [DATE], R1's paper chart included a green Practitioner Order for Life-Sustaining Treatment (POLST) form dated [DATE], and signed by V14 (R1's Physician and facility Medical Director). The POLST included R1's signature and in Box A, the option for Attempt Resuscitation/CPR (Selecting CPR means Full Treatment .) was checked. R1's [DATE] Brief Interview of Mental Status documents R1 as cognitively intact. On [DATE] at 11:53 AM V14 (Medical Director) confirmed R1 has expressed to him she does not want to live anymore. V14 stated this conversation occurred during his routine visit [DATE]. R1's Electronic Medical Record (EMR) shows a Progress Note dated [DATE] documenting V14 (Medical Director) provided an order for a hospice evaluation due to R1's refusal to eat and failure to thrive. This note further documents V10 (R1's State Guardian) was informed of R1's clinical situation and new orders for hospice. A note dated [DATE] documents R1's guardian was educated on the advantages of hospice and as providing consent for hospice services. A note dated [DATE] at 8:21 PM documents R1 had expired at approximately 5:20 PM. There is no documentation in the EMR between [DATE]-[DATE], indicating V10 was notified of R1's expressed wishes made to V14 or any other discussions were had with V10 to implement changes to R1's POLST form or advanced directives. R1's Physician Visit Notes, completed by V14 dated ,d+[DATE] and [DATE], document R1 as a full code. R1's Physician Visit Note, also completed by V14 dated [DATE], does not document her code status- this section was left blank. The Care Plan Summary and Attendance Record dated [DATE] documents R1 with cognitive impairments but able to understand others and make needs known. The Physician Summary section documents V14 was consulted for input into this care plan meeting; there is no documentation regarding R1's expressed advanced directives. The Care Level Review section for this meeting shows R1 as a full code. R1's Hospice Telephone Verbal Order form dated [DATE] shows R1 was admitted to hospice with a primary diagnosis of Dementia on this date. On [DATE] at 1:32 PM V2 (Director of Nursing) stated R1 was admitted to hospice on [DATE] because she was having gradual losses. V2 stated R1 was able to express herself and communicate her wishes and she was aware and okay with hospice care. V2 stated after hospice becomes involved, they take over and have the discussions with the resident and the guardian regarding advanced directives. V2 stated at the time of her death ([DATE]) hospice was in the process of implementing a Do Not Resuscitate Order (DNR) but hospice had not notified her they were communicating with V10 for consent. V2 stated, My assumption is she is on hospice, so she is a DNR. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1:20 PM V21 (Social Service Director) confirmed she was notified of R1's admission to hospice. V21 stated she had not pursued any discussions with R1 or V10 regarding R1's advanced directives. [DATE] 2:47 PM V8 (Hospice Nurse) stated R1 began declining the evening of [DATE] so he initiated a conversation with V10 regarding R1's advanced directives because R1 remained a full code. V9 stated he could not specify why R1's advanced directives were not address prior to [DATE] and would have expected those conversations to have already occurred. On [DATE] at 1:34 PM V9 (Hospice Nurse) stated code status is usually addressed upon admit to hospice; she is not aware of anyone addressing R1's code status prior to [DATE]. V9 stated the process for changing advanced directives at each facility is individualized and coordinated with the facility in each situation. On [DATE] at 9:45 AM V10 (R1's State Guardian) confirmed she was aware of R1's recent decline and consented to hospice. V10 stated as of [DATE] initial communications with hospice began regarding R1's advanced directives, specifically related to R1's full code status. V10 stated on [DATE] at 2:05 AM she received an email from V8 (Hospice Nurse) regarding R1's change in status and concerns that R1's advanced directives currently show R1 as a full code. V10 stated she then spoke with the hospice company again on [DATE] at 9:17 AM and reviewed the required process as a State Guardian to consider changing R1's code status. V10 confirmed no conversations regarding R1's advanced directives or code status occurred with her prior to [DATE]. V10 stated, I cannot change a resident's status without knowing their wishes. On [DATE] at 11:53 AM V14, Medical Director was asked if he thought a conversation with V10 and R1 regarding advanced directives should have occurred at the time she expressed her wishes, and then again at the time hospice was initiated on [DATE], he was not able to answer. R1's hospice Informed Consents/Election of Benefits Form was stamped and signed by R1's State Guardian and hospice company on [DATE], and it does not mention the completion of a POLST form or discussion of advanced directives. In section 2.1 Admission to Hospice Program under Article II: Services to be Provided by Hospice in the facility's Nursing Facility Hospice Services Agreement, it showed (c) Hospice shall notify Nursing Facility whether a resident is authorized for admission as a Patient and shall be responsible for obtaining all necessary admission forms, consents, and election statements from the Resident or, where applicable, the Resident's representative. The Article does not refer to hospice being responsible for obtaining a POLST form. 3. The facility Abuse Prevention Program policy dated [DATE] documents the facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property and exploitation. This policy documents the facility will take steps to prevent mistreatment, exploitation, neglect and abuse of residents and misappropriation of property while the investigation is underway, including any employ who has been accused of abuse or neglect will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator. The policy shows the summary, conclusions and results of the investigation will be recorded on a final written incident report which is to be submitted to the state agency within five working days of the occurrence. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Reporting Officer statement from the [DATE], local Police Department's preliminary Case Report Summary showed .On [DATE] at 18:57 [6:57 PM] .responded .for deceased patient at [facility address]. Due to some uncertainty, dispatch clarified that this was not an in-progress emergency, rather the patient, [R1] . had been deceased for some time. This document shows the timeline obtained by the officers during interviews conducted with the witnesses on [DATE] as follows: R1 was discovered deceased between 5:, d+[DATE]:20 PM by V6 (Nursing Assistant) who then alerted V5 (Nurse). V5 stated to the officer she then spent the time between discovering R1 was deceased up to the time 911 was contacted at 6:57 PM attempting to locate R1's DNR paperwork, contacting hospice, and the state guardian. This report shows a hospital physician provided a time of death to the paramedics as 7:20 PM. On [DATE] between 10 AM- 3 PM, V5 was observed working as a floor nurse, administering medications and caring for residents. On [DATE] at 2:13 PM V1 (Administrator) stated she is still investigating the circumstances surrounding the incident of [DATE] when V5 did not implement CPR when she found R1 expired. The undated facility final investigative report of R1's death investigation does not document a final investigative summary and outcome. On [DATE] at 1:32 PM when asked about V5's presence at the facility, V2 (Director of Nursing) stated I called the agency to get her educated and they did do that. On [DATE] at 11:20 AM V26 (Regional Director of Operations) stated, The nurse should have been off during an active investigation.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30973 Based on interview and record review the facility failed to coordinate advanced directives with hospice and a guardian in a timely manner. This applies to 1 of 2 residents (R1) reviewed for hospice care in a sample of 100. Findings include: R1's Admission Record dated [DATE] documents R1 as an [AGE] year-old with diagnoses to include Bipolar Disorder, Dementia, and Schizoaffective Disorder. R1's Circuit Court Letters of Office Guardianship of a Disabled Person dated [DATE] documents R1 as a disabled person totally without capacity per physician and therefore ordered a plenary guardian of person. On [DATE], R1's paper chart included a green Practitioner Order for Life-Sustaining Treatment (POLST) form dated [DATE], and signed by V14 (R1's Physician and facility Medical Director). The POLST included R1's signature and in Box A, the option for Attempt Resuscitation/CPR (Selecting CPR means Full Treatment .) was checked. R1's [DATE] Brief Interview of Mental Status documents R1 as cognitively intact. On [DATE] at 11:53 AM V14 (Medical Director) confirmed R1 has expressed to him she does not want to live anymore. V14 stated this conversation occurred during his routine visit [DATE]. R1's Electronic Medical Record (EMR) shows a Progress Note dated [DATE] documenting V14 (Medical Director) provided an order for a hospice evaluation due to R1's refusal to eat and failure to thrive. This note further documents V10 (R1's State Guardian) was informed of R1's clinical situation and new orders for hospice. A note dated [DATE] documents R1's guardian was educated on the advantages of hospice and as providing consent for hospice services. A note dated [DATE] at 8:21 PM documents R1 had expired at approximately 5:20 PM. There is no documentation in the EMR between [DATE]-[DATE], indicating V10 was notified of R1's expressed wishes made to V14 or any other discussions were had with V10 to implement changes to R1's POLST form or advanced directives. R1's Physician Visit Notes, completed by V14 dated ,d+[DATE] and [DATE], document R1 as a full code. R1's Physician Visit Note, also completed by V14 dated [DATE], does not document her code status- this section was left blank. The Care Plan Summary and Attendance Record dated [DATE] documents R1 with cognitive impairments but able to understand others and make needs known. The Physician Summary section documents V14 was consulted for input into this care plan meeting; there is no documentation regarding R1's expressed advanced directives. The Care Level Review section for this meeting shows R1 as a full code. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Hospice Telephone Verbal Order form dated [DATE] shows R1 was admitted to hospice with a primary diagnosis of Dementia on this date. On [DATE] at 1:32 PM V2 (Director of Nursing) stated R1 was admitted to hospice on [DATE] because she was having gradual losses. V2 stated R1 was able to express herself and communicate her wishes and she was aware and okay with hospice care. V2 stated after hospice becomes involved, they take over and have the discussions with the resident and the guardian regarding advanced directives. V2 stated at the time of her death ([DATE]) hospice was in the process of implementing a Do Not Resuscitate Order (DNR) but hospice had not notified her they were communicating with V10 for consent. V2 stated, My assumption is she is on hospice, so she is a DNR. On [DATE] at 1:20 PM V21 (Social Service Director) confirmed she was notified of R1's admission to hospice. V21 stated she had not pursued any discussions with R1 or V10 regarding R1's advanced directives. [DATE] 2:47 PM V8 (Hospice Nurse) stated R1 began declining the evening of [DATE] so he initiated a conversation with V10 regarding R1's advanced directives because R1 remained a full code. V9 stated he could not specify why R1's advanced directives were not address prior to [DATE] and would have expected those conversations to have already occurred. On [DATE] at 1:34 PM V9 (Hospice Nurse) stated code status is usually addressed upon admit to hospice; she is not aware of anyone addressing R1's code status prior to [DATE]. V9 stated the process for changing advanced directives at each facility is individualized and coordinated with the facility in each situation. On [DATE] at 9:45 AM V10 (R1's State Guardian) confirmed she was aware of R1's recent decline and consented to hospice. V10 stated as of [DATE] initial communications with hospice began regarding R1's advanced directives, specifically related to R1's full code status. V10 stated on [DATE] at 2:05 AM she received an email from V8 (Hospice Nurse) regarding R1's change in status and concerns that R1's advanced directives currently show R1 as a full code. V10 stated she then spoke with the hospice company again on [DATE] at 9:17 AM and reviewed the required process as a State Guardian to consider changing R1's code status. V10 confirmed no conversations regarding R1's advanced directives or code status occurred with her prior to [DATE]. V10 stated, I cannot change a resident's status without knowing their wishes. On [DATE] at 11:53 AM V14, Medical Director was asked if he thought a conversation with V10 and R1 regarding advanced directives should have occurred at the time she expressed her wishes, and then again at the time hospice was initiated on [DATE], he was not able to answer. R1's hospice Informed Consents/Election of Benefits Form was stamped and signed by R1's State Guardian and hospice company on [DATE], and it does not mention the completion of a POLST form or discussion of advanced directives. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In section 2.1 Admission to Hospice Program under Article II: Services to be Provided by Hospice in the facility's Nursing Facility Hospice Services Agreement, it showed (c) Hospice shall notify Nursing Facility whether a resident is authorized for admission as a Patient and shall be responsible for obtaining all necessary admission forms, consents, and election statements from the Resident or, where applicable, the Resident's representative. The Article does not refer to hospice being responsible for obtaining a POLST form. The Advanced Directive Policy dated [DATE] documents the Patient Self Determination Act states that individuals have the right to make their own decisions, and to formulate advance directives to serve as decisions when the individual is incapacitated. Any decision regarding advanced directives made by the resident shall be indicated in the chart. Any advance directive will be reviewed quarterly with the interdisciplinary team and the resident/responsible party. Advance directives may be reviewed more frequently as condition warrants.