

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER Spencer Post Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 711 West 11th Street Spencer, IA 51301	

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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35438</p> <p>Based on clinical record review, staff interviews, personnel records and facility policy review on [DATE] the facility staff failed to implement CPR (cardiopulmonary resuscitation) for one of five residents sampled (Resident #1), who was found unresponsive with no pulse or respirations and desired CPR. This resulted in immediate jeopardy to the residents health and safety. The facility identified a census of 53 current residents, 13 of which were identified by the facility with a request for CPR at the time of cardiopulmonary or respiratory arrest.</p> <p>The facility was notified of the Immediate Jeopardy (IJ) and given the IJ template on [DATE] at 12:15 PM. The immediacy had been removed on [DATE] when the facility provided staff education and review of their policy. The citation is considered a past non-compliance as the facility implemented plan of correction prior to the surveyors entrance on [DATE].</p> <p>Findings include:</p> <p>1. A Minimum Data Set (MDS) assessment with a reference date of [DATE] documented Resident #1 was admitted to the facility from the hospital on [DATE] and a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognitive skills for decision making. According to the MDS the resident required substantial/maximal assistance with sit to stand and chair to bed transfer and had diagnosis that included fracture of the left wrist and hip.</p> <p>An undated Admission Care Plan documented under the heading of Advance Directives Resident #1 was a Full Code.</p> <p>A document titled Cardiopulmonary Resuscitation (CPR) Directive documented that it is the policy of the facility to provide basic CPR to those resident who chose it. The document was signed and dated on [DATE] by Resident #1 indicating by a check mark that the resident had requested CPR be initiated when her heart had stopped beating and/or she had no pulse. The residents signature further documented that she understood that if she wished for CPR at the time her heart stopped beating and/or she had no pulse, basic life support procedures would be provided until paramedics arrive. The directive was signed by the provider on [DATE].</p> <p>Review of an Order Recap Report for Resident #1 documented an order dated [DATE] that the resident was a full code.</p> <p>(continued on next page)</p>

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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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The electronic health record contained the Admission Record, commonly known as the face sheet, documented under the heading Advance Directive: Full Code.</p> <p>An electronic Progress Note dated [DATE] at 7:00 a.m. revealed documentation by Staff A, Licensed Practical Nurse (LPN) included the following: Certified Nursing Assistant (CNA) summoned to the residents room. Resident laying on bed with eyes open and fixed. Resident had no pulse, no blood pressure, and not breathing which was verified by a second nurse. The family and funeral home were notified.</p> <p>An electronic Progress Note dated [DATE] at 7:20 a.m. revealed Staff B, Registered Nurse, (RN) was called to verify absence of vital signs. CNA was in room and had just finished completing post mortem cares. Verified absence of apical and radial pulse and noted skin cool to touch.</p> <p>Review of a facility electronic Incident Report dated [DATE] at 4:33 p.m. initiated by the Director of Nursing (DON) revealed CNA had summoned the charge nurse on duty to the residents room Resident was lying on the bed, eyes open and fixed. The resident had no pulse, no blood pressure and was without respirations noted. This was verified by a second nurse and the residents daughter was notified. The coroner arrived at the facility to assess resident. Immediate action taken included: all staff educated on the importance of CPR policy and protocol and what to do in the event of a non-responsive resident.</p> <p>During an interview on [DATE] at 9:40 a.m., Staff C, CNA stated on [DATE] at approximately 7:00 a.m. she heard Resident #1's audible call light tone and approximated had responded to the room within ,d+[DATE] minutes. Staff C described that she walked into the room, turned off the call light at the bedside, and questioned what can do for resident? The resident hadn't answered so she rubbed her chest and asked again. The resident failed to respond then Staff C noticed her gaze was fixed. Staff C stated that knew something was wrong immediately so summoned the nurse. Staff C described that the resident was still warm to the touch, and her skin tone was pink. Staff C recalled that Staff A, LPN was in the hallway a couple rooms away, and responded to the room right away. Staff A, LPN entered the room, observed the resident, left and returned right away with a stethoscope, listened to resident's chest and commented there was nothing. Staff C described that as Staff A was assessing the resident, the resident took several sharp incomplete breaths, more of an inhale. Staff C stated that Staff A had also noticed the breaths as she had made the comment that she didn't know what those breaths were all about. Staff A, LPN then left the room, and didn't return. Staff C stated that she was in the room at all times, and CPR was not initiated.</p> <p>During an interview on [DATE] at 10:15 a.m. Staff B, Registered Nurse (RN) stated she had been called at approximately 7:20 a.m. as the second nurse to confirm the absence of vital signs. Staff B stated when she entered the room, Staff C, CNA had just finished post mortem cares. Staff B responded that she was not aware that Resident #1 was a full code until later, had not thought to question Staff A, LPN. Staff B further stated that if a resident was found unresponsive would expect the nurse to call for help, check for code status, and start CPR if the resident was a full code. Staff B, RN responded that she had not initiated CPR.</p> <p>In an interview on [DATE] at 10:40 a.m. Staff D, CNA responded she had heard Resident #1's call light, but it had gone off quickly, approximated within a couple of minutes, so knew that it had been answered.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:00 a.m. Staff A, LPN stated she had been summoned to Resident #1's room by Staff C, CNA that resident #1 had passed. Staff A further described when she entered the room noted that the resident had a fixed stare, was pale and that the resident was not cool to touch, but also not warm. Staff A stated she had noticed Resident #1's call light was on and was heading that way but saw Staff C, CNA go into the room. Staff A stated she had not checked the residents code status, and had not started CPR. Staff A responded that she should have checked the code status, had someone call 911, and started CPR.</p> <p>In an interview on [DATE] at 4:05 p.m. the Director of Nursing (DON) stated that on [DATE] had become aware that Resident #1 had passed and was a full code. The DON stated she had questioned Staff B, RN if CPR had been initiated and was informed that CPR had not been performed. The DON interviewed Staff A, LPN who admitted that she was aware Resident #1 was a full code, but that she was already gone when she entered the room so hadn't started CPR. The DON informed that Staff A was terminated as a result of the investigation. The DON further stated that would expect staff to start CPR in a witnessed code situation when the resident had requested resuscitation. The DON further stated that code status was available in the Electronic Health Record. The DON confirmed Resident #1 had a current and active order for CPR</p> <p>Review of a facility personnel form titled Termination Form dated [DATE] documented Staff A, LPN was involuntary terminated for gross misconduct and death. The form contained further explanation for the termination that included: On [DATE] Staff A was on shift and made aware that the resident was unresponsive, the resident was a full code and the employee failed to attempt resuscitation. Per the employee's job description that was reviewed and signed on [DATE] by Staff A, the employee was to administer services within the applicable scope of nursing practice to residents. Staff A failed to adhere to the essential duty and responsibility of performing CPR on a resident that was noted as a full code. Due to the severity of this action Staff A was terminated as of today [DATE].</p> <p>Review of a facility policy/procedure titled Cardiopulmonary Resuscitation (CPR) identified that it is the policy of the facility to administer CPR according to current national guidelines. The policy included the following guidelines: Once CPR is initiated, it will be discontinued only by a physician's order and/or the arrival of rescue personnel who take over CPR efforts and/or transport the resident. Only staff members certified to perform CPR should perform the procedure.</p> <p>Review of a card dated as issued [DATE] certified that Staff A, LPN had successfully completed the Healthcare Provider (BLS) Adult, Child and Infant CPR course.</p> <p>The facility identified a total of 13 residents with request for full code (CPR).</p>		