STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265185	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Cape Girardeau	365 South Broadview Street Cape Girardeau, MO 63703

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** Based on interview and record review, the facility failed to ensure an accurate and consistent system was in place to direct staff when to initiate basic life support for one resident (Resident #1), when on [DATE] at around 10:25 P.M., staff entered the resident's room and found the resident unresponsive with no respirations. Cardiopulmonary resuscitation (CPR - a procedure performed usually involving chest compressions and assisted breathing to revive a person's life) was initiated by facility staff with notification to emergency medical services (EMS) and hospice services. The resident's facility medical record showed a full code status order was entered on [DATE], without any documentation of the resident's wishes or consent for a full code status. The resident's hospice record located in the facility showed the resident's consent and an order for do not resuscitate (DNR) on [DATE], with documentation of the conversation for the DNR as per the resident's choice. The facility census was 92. On [DATE] at 4:25 P.M., the Director of Nursing (DON) was notified of the immediate jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the facility's policy titled, Advance Directives and Advance Care Planning, dated [DATE], showed: - Residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute an advance directive; - It is required that the patient is asked about advanced directives, and to document any wishes the patient might have with regard to the care they want or do not want; - The facility is not relieved of its obligation to provide this information to the individual once he/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; - Do Not Resuscitate order -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. Existence of an advance directive does not imply that a resident has a DNR order. The medical record must show evidence of documented discussions leading to a DNR order; (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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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Competent - Residents have the right to actively participate in their plan of care. The resident has the right to designate a representative, in accordance with State law, and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. A resident is competent to make a health care decision if he/she understands the nature of his or her illness, understands the treatment options available to him/her, understands the consequences of refusing such treatments, and is able to make and communicate decisions about his/her medical treatment; - Residents or their responsible parties receive materials concerning their rights under applicable laws to make decisions regarding their medical care, including the right to accept or refuse medical care, the right to accept or refuse medical/surgical treatment, organ donation requests, and the formation of advance directives upon admission; - A written description of the facility's policies regarding advance directives and applicable State law is provided to the resident or resident representative. Information is provided in a manner easily understood by the resident or resident representative; - The resident and/or family, upon admission, to determine the need and knowledge relative to advance directives and advanced care planning; - Residents may revise an advance directive either orally or in writing. With an oral reversal, charting is due immediately, the physician is notified immediately, an immediate notation is made on the care plan, and an immediate entry is made in the medical record. With written reversals, the physician is notified, and the plan is permanently adjusted. The physician must give an order for any changes in the advance directives; - If the resident leaves the facility temporarily (e.g., emergency room visit, hospital stay, or diagnostic procedure), a copy of the advance directive is sent with the resident. The facility should also ensure advance directive status (e.g., DNR) is communicated to the receiving provider and transporting provider; - Each time the resident is admitted to the facility, quarterly, and when a change in condition is noted in the resident condition, the facility should review the advance directive and advance care planning (ACP) information. This review should focus on if the existing advance directives and ACP match the current goals of care for the resident. The social services director or designee should document this conversation in the medical record and assist as needed with updating the documents that need revision in accordance with state and federal requirements; - Residents who are competent at the time of admission and who have not previously executed an advance directive are given the opportunity to do so with the assistance of an interdisciplinary team, consisting of, but not limited to: the Medical Director, Executive Director, DON, Director of Social Services, chaplain, and others as appropriate. Social Services ensures that a copy of the advance directive is obtained for the resident's medical record and verifies that there is an appropriate physician's order in the resident's medical record as well; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Documentation in the Minimum Data Set (MDS - a federally mandated assessment to be completed by facility staff) should reflect the appropriate advance directives. This information is reviewed or updated, as appropriate, at least quarterly or more frequently if there is a significant change in the resident's medical condition. Each quarter the care plan team reviews with the resident, his/her advance directives to ensure that they are still the wishes of the resident. Such reviews are made during the quarterly assessment process and recorded on the Resident's Assessment Instrument (RAI); - DNR - Regardless of whether the resident is in a persistent vegetative state or has a terminal condition, all Life Care Centers of America's residents receive full resuscitative measures unless a DNR is written in the resident's medical record and is identified in the resident's advance directive. While the physician's order is pending, the documented verbal wishes of the resident or resident's representative regarding DNR status will be honored, unless state specific guidelines differ; - Social Services or Nursing Administration's documentation of the DNR must be present in the medical record regarding the DNR status and discussion with the resident and/or resident's representative on the consequences and implications of this status. The physician is notified regarding any questions concerning the appropriateness of the resident's code status; - A physician's order and written consent from the resident or resident's representative must be obtained. While the physician's order is pending, staff should honor the documented verbal wishes of the resident or the resident's representative regarding CPR unless state-specific regulations differ; - DNR order is flagged appropriately on the resident's chart to alert staff as to status; - Social Services and/or a member of Nursing Administration reviews the DNR status with the resident and/or family and the receiving physician within 72 hours of admission; - The resident or resident's representative must sign an informed consent as required by state specific requirement indicating that the resident consents to a DNR or no CPR or no resuscitation in the event of cardiac arrest or respiratory failure; - The DNR order is incorporated into the resident's care plan and is periodically reviewed, at least quarterly, including supportive care and comfort measures. These measures will not be withheld when a DNR order exists; - DNR orders may be revoked at any time but must be documented in the resident's chart as such with consent of the resident or the resident's representative; - The resident's physician is notified of any change in condition regardless of the DNR order; - The DON or designee establishes a system to inform all direct care staff of the resident's DNR status; - If the resident is discharged from the facility and re-admitted , the DNR status must be reviewed to determine if it is still appropriate and desired by all parties involved. A new order for DNR is obtained at that time. 1. Review of Resident #1's medical record showed: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- An admission date of [DATE]; - A Code Status form signed by the resident on [DATE], with both full resuscitation and Do Not Attempt Resuscitation (DNAR - no medical procedures or measures of resuscitation would be taken including no CPR and not calling 911) marked with an X with a line through the full resuscitation X; - No documentation of a code status in the Resident admission Agreement; - No documentation of a baseline care plan (basic information of resident done with 48 hours of admission) that addressed the resident's code status; - An order for a Full Code status, dated [DATE]; - No documentation of any contact with the resident, the resident's family, or the physician to obtain a proper authorization for a code status change from DNR to Full Code. Review of the resident's hospice binder showed: - Long-term Care/Hospice Coordination of Care Form with code status marked DNAR signed by Hospice Intake Coordinator Nurse H and a facility staff member on [DATE]; - A progress note, dated [DATE] from 2:33 P.M. - 3:46 P.M., showed Hospice Intake Coordinator Nurse H met with the resident at the hospital to sign the hospice admission paperwork. The hospice admission paperwork was discussed with the resident. All of the paperwork was signed by the resident. The hospice admission paperwork discussion included the home DNR form, the outside the hospital DNR form, the hospice consent for treatment, the release of information, and the acknowledgement of information form. The admission form was given to the resident. The resident did not have a durable power of attorney (DPOA) and said he/she had no one but himself/herself. The resident was alert and oriented times four. Vital signs were taken and a full assessment was completed. Medications were reviewed with the resident and the facility nurse. Orders were given to the facility nurse and all questions answered. Instructed to contact the hospice nurse 24 hours a day seven days a week with any questions, concerns, or changes in the resident's condition. Discussed who the hospice nurse and the aide would be and what days they would be making visits; - A code status order signed on [DATE] at 10:48 A.M. by the hospice physician for a no code blue (chest compressions or medications to restart the heart if it stops)/no intubation (breathing tube inserted into the trachea to help with breathing). Review of the facility's investigation of the resident's event on [DATE] showed: - A witness statement, dated [DATE], Licensed Practical Nurse (LPN) D said on [DATE] at 10:25 P.M., LPN D was called to the resident's room by other staff and said the resident was not breathing. A crash cart was brought to the resident's room and CPR was started. EMS was called by a CNA. At 10:33 P.M., Hospice Registered Nurse (RN) G entered the resident's room and said no need to continue CPR as the resident was a no code by the hospice paperwork and advised EMS staff there was no need to enter the facility. At 10:48 P.M., Hospice RN G exited the facility and said he/she would return to the facility to complete the needed paperwork; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- A witness statement, dated [DATE], showed CNA E said on [DATE], LPN D told him/her to call ambulance services because the resident was unresponsive. He/She called EMS, returned to the resident's room, and helped assist with CPR until the facility nurse came in and said to stop because the hospice nurse said the resident had DNR papers. Observation and interview on [DATE] at 2:30 P.M. showed: - LPN A said he/she noticed shortly before he/she left on the day shift on [DATE], the resident did not have a code status listed in PCC, so he/she entered it. Staff used the code status that was listed in PCC. Staff entered the resident's information in PCC on [DATE], when the resident was admitted , but didn't list the code status. LPN A did not discuss the code status with the resident on [DATE], because he/she was asleep. He/she looked at the resident's facility admission paperwork which listed him/her as a full code; - LPN A reviewed the resident's admission paperwork packet and he/she could not find the form he/she was referring to for the resident's full code status. LPN A said the nurse that admitted the resident was supposed to complete the paperwork and then the health medical records person was supposed to scan the documents into the resident's file. During an interview on [DATE] at 10:57 A.M., LPN B said the resident was alert and oriented times four and able to make his/her own decisions. He/She finished the admission paperwork on [DATE], since it was not completed on [DATE], when the resident was admitted . The admission paperwork should be completed within the first 24 hours of being admitted . All of the resident's orders in PCC were messed up or not there. The hospice nurse was there the morning of [DATE], for the first two to three hours of his/her shift and helped him/her straighten out the orders. He/She did not recall seeing the hospice binder, but did interview the resident on [DATE], and the resident said he/she wanted to be a full code. He/She did not document this discussion in the resident's medical record. At the time of the discussion, the hospice nurse had already left the building, but was supposed to come back later in the day. By the time the hospice nurse came back, he/she had forgotten to tell the hospice nurse what the resident's wishes were. The admission paperwork was put in a basket by the fax machine and someone came by to collect it and scan the information into the computer. He/She would usually put a code status order in PCC, but since the resident was hospice, hospice residents were usually DNR and this resident wanted to be full code, he/she wanted to clarify the code status change first. He/She gave report to LPN D on [DATE] at around 6:00 to 6:30 P.M. and the resident was at baseline at that time. He/She would look in PCC to see what the code status of the resident would be. The facility had a lot of travel agency workers who often had a lack of communication with what went on in the facility. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:30 A.M., LPN C said he/she remembered working night shift on [DATE], and the resident was alert and oriented with a little confusion at times. He/She made his/her needs known. LPN C said he/she thought it was given in report the resident was a DNR, but had mentioned wanting to change to full code status and gave the same information to the next shift, LPN B, on [DATE]. He/She did not verify the code status with the resident and did not do the admission paperwork, but did help with the admission process by doing the admission assessments. He/She did not do any admission paperwork, but did remember seeing a white binder with the resident's hospice information in it. He/She did not remember looking at the information or what the binder showed was the resident's code status was. He/She would look for the code status in PCC and if it was not signed by the physician and by the resident or the resident representative, then he/she would go by the last known legal code status on file. During an interview on [DATE] at 9:27 A.M., Hospice Manager F said he/she prepared the hospice binders. The hospice binders included all necessary orders, forms, care directions, and staff information related to the resident's care. Once the binder was together, then Hospice Intake Coordinator H delivered the binder to the facility. The intake coordinator conducted a meeting with the resident and the facility staff to review and sign the necessary forms, go over care instructions, and then left the hospice binder at the facility. The hospice binder remained at the facility until the resident expired. After the resident expired, the documents were left with the facility and the empty binder would be taken back to the hospice office. During an interview on [DATE] at 10:02 A.M., Hospice Intake Coordinator Nurse H said Hospice Office Manager F assembled the hospice binders. He/She brought the hospice binder, the field chart, and the signable forms to complete the resident's in-person admission that was put together by Hospice Office Manager F to the facility. He/She met the resident and the resident's facility primary nurse on [DATE]. During the visit on [DATE], both the facility nurse and the resident signed the Long-Term Care Hospice Coordination of Care Form, which showed the resident's DNR code status. He/She reviewed the medications with the facility nurse who signed off on the medications. He/She also went over the resident's plan of care and answered any questions for the facility nurse. After the admission was complete, he/she left the hospice binder, which included the resident's DNR documentation, at the facility. The DNR documentation details included a Hospital DNR that was already signed by the physician, a Hospice DNR order with a verbal consent order by the physician obtained on [DATE], and the signed order by the Hospice physician on [DATE]. The binder included multiple references to the resident's DNR code status. The hospice binder remained in the facility until after the resident expired. After the resident expired, the hospice staff would leave all of the resident's documents from the hospice binder with the facility and retrieve the empty binder. He/She recalled Hospice RN I did his/her first visit on [DATE], and noted the binder was missing from the usual location. The binder was found later at the nurse's station among other binders. During an interview on [DATE] at 10:17 A.M., Hospice RN I said he/she was the primary hospice nurse assigned to the resident and completed the first facility visit on [DATE]. On arrival to the facility on [DATE], the hospice binder was not in the usual location which was a small room behind the nurse's station. He/She eventually found the binder in with other binders on the nurse station desk. He/She spoke with LPN B and found the orders for the resident were messed up. He/She had to provide updated orders to the facility nurse before ending the visit on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:59 A.M., Hospice RN G said he/she received a phone call from LPN D who said the resident was actively coding on [DATE]. He/She was about three minutes from the facility and informed LPN D the resident was a DNR and the hospice binder should confirm that information. Upon arrival to the facility, LPN D was at the front desk looking through the hospice binder. The hospice binder showed the resident was a DNR and should not have been coded. He/She did not enter the facility beyond the front desk and did not witness the code. He/She did not know the exact details of what occurred. EMS arrived shortly after him/her, but the facility nurse stopped EMS at the door and said they were no longer needed. EMS did not enter the facility. He/She then left the facility to answer another hospice patient's needs. He/she returned to the facility within one to one and a half hours, and completed the usual post-death procedures. During an interview on [DATE] at 2:40 P.M., the Director of Nursing (DON) said addressing a resident's code status should be one of the first things done when admitting a new resident. The nurses on the unit were responsible for filling out the admission paperwork packet and it should address the code status. The code status should match between the hospice record and the facility record. The Care Profile in PCC should show the current accurate code status. During a phone interview on [DATE] at 3:12 P.M., the Medical Director said he/she was told about the incident with the resident's code status. He/She did not sign a DNR order. If the resident wanted to be a full code and had conversations with the facility staff about it, then those conversations should be documented somewhere in the resident's medical record. The facility should have the code status and the resident's wishes of a newly admitted resident within 24 hours of admission. The resident's code status should match throughout the resident's medical record. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Complaint #MO00256082