STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265696	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Platte City	220 O'Rourke Drive Platte City, MO 64079

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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 - 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** 44939 Based on interview and record review, the facility failed to follow their policy and ensure two sampled resident's (Resident #1 and #2) code status was correct at the time of admission and carried out in accordance with the guardian's directive to staff. Resident #1's guardian directed Registered Nurse (RN) A upon admission on [DATE] and to RN B on [DATE] to change the resident's code status to Do Not Resuscitate (DNR). On [DATE], the resident stopped spontaneous respirations and pulse and facility staff initiated cardiopulmonary resuscitation (CPR). Emergency Medical Services (EMS) were called to the facility and took over CPR from facility staff. CPR was performed for one hour and 13 minutes. The resident was declared deceased at the facility on [DATE] at 2:16 A.M. Resident #2's guardian notified the Social Services Designee (SSD) on [DATE] of his/her wishes to change the resident's code status from full code to a DNR and staff failed to change the resident's code status. The facility census was 68. The Administrator was notified on [DATE] at 2:24 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor on site. Review of the undated facility policy regarding Health Care Directives/Death of a Resident showed: -Purpose: Ensure that the facility is able to, and does provide, emergency basic life support when needed, including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with the related physician orders, such as DNR and the resident's advanced directives. - Advanced Directives is defined as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Some states also recognize documented verbal instruction. - CPR refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased. - Code Status refers to the level of medical interventions a person whishes to have started if their heart or breathing stops. (continued on next page)

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	- DNR order 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. Existence of an advanced directive does not imply that a resident has a DNR order. The medical record should also show evidence of documented discussions leading to a DNR order. Review of the undated facility policy regarding DNR- No Extraordinary Life-Saving Measures: -Purpose: Ensure that resident rights are protected in the presence of a DNR order or Advanced Directive, when the resident wishes for no extraordinary measures to be taken at his/her end of life. -Procedure: - When a resident discusses with a staff member the desire for no extraordinary life-saving measures, the Director of Nursing (DON) will be notified. - The DON will have a more formal discussion with the resident about what no extraordinary life-saving measures means. - This wish will be shared with the resident's family, responsible party, and physician. - A copy of these documents will be maintained in the resident's file, given to the resident family or responsible party and given to the resident's physician. - If the resident has a Health Care Proxy, the EMS/ambulance will be informed as needed and the person with Health Care Proxy will be contacted as needed. That person's phone number will be placed in the resident's chart so they can be contacted during an emergency when the resident is not capable of making healthcare decision. - A copy of the Living Will, Advanced Directives or Health Care Proxy will be sent with the ambulance workers. 1. Review of Resident #1's Admission Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated [DATE], showed: -the resident admitted to the facility on [DATE]; -diagnoses of neurocognitive disorder with Lewy Bodies (a common dementia is caused by a buildup of proteins in the brain. It affects thinking, memory and movement), hallucinations, constipation, arthritis, anemia, chronic pain. -had minimal difficulty hearing, clear speech, sometimes understands others and rarely/never is able to make self understood; -score of ,d+[DATE] on the Brief Interview for Mental Status (BIMS, a brief cognitive screening tool used to measure and track resident's cognitive decline or improvement in long-term care), indicating severely impaired cognition; and (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-was dependent on staff for all activities of daily living, including dressing, bathing, and personal hygiene. Review of the resident's medical record showed the resident's daughter was granted legal guardianship of the resident on [DATE]. Review of the resident's face sheet, dated [DATE], showed the resident's code status to be Full Code/CPR. Review of the resident's physician orders, dated [DATE], showed an order for the resident's code status as Full Code/CPR. Review of the resident's comprehensive care plan, dated [DATE], showed the resident wished to be a Full Code status. In case of no pulse, no respirations start CPR and call 911. Review quarterly with resident, responsible party and with significant changes to ensure wishes remain the same. Review of the resident's progress notes showed: -[DATE] 3:17 P.M.: RN A wrote: Resident was admitted on [DATE]. Resident is a DNR. Face Sheet and orders faxed to the physician and to pharmacy. -[DATE] 4:46 P.M.: RN B wrote: Guardian was here. Was discussing the resident's care. The guardian noted resident was a DNR, but nothing was in the file stating the resident was a DNR. The Guardian said he/she gave the document to someone in the office here. Will let executive director (ED) know of code status. Let physician know as well. (Review of the medical record showed no documentation that the physician was notified of the desired code status.) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident's family arrived at the facility and adamantly informed ambulance crew that the patient has a DNR and does not wish to be resuscitated. At that time it was decided by the ambulance crew that the patient has undergone significant resuscitation efforts and that further efforts would likely not benefit the resident. Medical control was contacted through the local hospital and the physician gave the order to cease CPR efforts. CPR efforts were ceased where it appeared the resident had agonal breathing (refers to short, labored, gasping breaths that occur because oxygen cannot reach the brain). Palpation of pulses was attempted by multiple providers where no pulse could be found. At that time, the ambulance crew returned their equipment to the ambulance and cleared the scene. -The resident was declared deceased at 2:16 A.M. During an interview on [DATE] at 2:11 P.M., the resident's guardian said: -He/she never received a form to sign to change the resident's code status. -He/she told the nurse at admission. The guardian also told RN B on [DATE] that the resident's code status should be DNR, not Full Code/CPR. He/she also had a discussion with the SSD in [DATE] regarding the resident's desired code status of DNR. He/she is unsure of the exact date of the conversation with SSD. -During the night of [DATE], the facility called the guardian to state that the resident had stopped breathing and CPR had been started. The guardian became very upset and requested multiple times that CPR be stopped. -He/she says the resident would not have wanted to have CPR performed. During an interview on [DATE] at 12:33 P.M., the Business Office Manager (BOM) said: -He/She completed a portion of Resident #1's admission, but did not speak to the family about the desired code status; -It was the SSD responsibility to obtain the resident's code status at the time of admission. During an interview on [DATE] at 11:21 A.M., RN A said: -He/She does not recall doing the admission for Resident #1, as he/she does so many admissions. -During the admission process, he/she will ask the resident or family their wishes for code status. If the resident or family has not made that choice, then the resident will be a full code. -Social Services is responsible for getting the code status choice from the resident and/or family, getting the code status form signed and the chart updated. During an interview on [DATE] at 11:26 A.M., the Social Services Designee (SSD) said: -He/She did not complete Resident #1's admission. The Business Office Manager (BOM) was completing admissions at that time; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-a score of ,d+[DATE] on the BIMS, indicating severely impaired cognition. Review of the resident's medical record on [DATE] showed the resident's son was appointed his/her legal guardian on [DATE]. Review of the resident's physician orders, dated [DATE], showed an order for the resident's code status to be Full Code/CPR. Review of the resident's face sheet, dated [DATE], showed the resident's code status to be Full Code/CPR. Review of the resident's comprehensive care plan, dated [DATE], showed: -the resident and his/her responsible party wish for the resident to have a CPR code status; and -code status will be reviewed quarterly and as needed with the resident and responsible party. Review of the resident's progress notes showed: -[DATE] at 5:56 P.M. SSD wrote: SSD was able to reach resident responsible party. Responsible party states he/she would like to change resident to DNR code status and would be here in the morning to sign and understands the resident will be a full code until the DNR is signed. Observation on [DATE] at 11:55 A.M., showed the dot on the name plate to be green, indicating the resident is a Full Code/CPR code status. Observation on [DATE] at 12:00 P.M., showed the resident to be a Full Code/CPR code status in the Code Status book. During an interview on [DATE] at 1:07 P.M., the SSD said: -Resident #2's guardian has not been to the facility to sign the DNR form. He/She will follow up with the guardian today and email him/her the form; -he/she had not notified the charge nurse or DON regarding the guardian's direction to change the resident's code status to DNR; and -he/she had received education regarding the process of changing a resident's code status. 3. During an interview on [DATE] at 12:27 P.M., the DON said: -it is his/her expectation that the code status be obtained on the day of admission and staff inform him/her of the desired code status; -it is his/her expectation that the charge nurse notify the physician of the desired code status, obtain the order and then update the chart. The SSD will update the Code Status book and the dot on the name plate; and (continued on next page)

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