STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395311	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Extended Care Center	956 Railroad Avenue Bryn Mawr, PA 19010

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** 38735 Based on a review of established guidelines for cardiopulmonary resuscitation (CPR), review of facility's policies, residents' clinical records, and staff interviews, it was determined that the facility failed to ensure that CPR was provided in accordance with established facility policy for one of eleven residents reviewed (Resident 207), creating a situation in which the residents were placed in Immediate Jeopardy related to failure to perform cardiopulmonary resuscitation immediately. (Resident 207) Findings include: Review of guidelines from the American Heart Association (AHA), dated 2020, revealed, the AHA urged all potential rescuers to initiate CPR unless a valid Do Not Resuscitate (DNR) order was in place; if there were obvious clinical signs of irreversible death present, including rigor mortis (stiffness of the limbs and body that develops 2 to 4 hours after death and may take up to 12 hours to fully develop), dependent lividity (reddish-blue discoloration of the skin resulting from the gravitational pooling of blood in the lower lying parts of the body in the position of death), decapitation (separation of the head from the body), transection (division by cutting across the body), or decomposition (decay); or if initiating CPR could cause injury or peril to the rescuer. Review of the facility's policy titled Cardiopulmonary Resuscitation (CPR), revision date [DATE], stated that CPR will be provided to all residents/patients who experience cardiopulmonary arrest unless one or more of the following is present: A valid Advance Directive or POLST/MOLST/POST/MOST requesting withholding of CPR. A properly executed and witnessed Do Not Resuscitate (DNR) order. Documented verbal wishes by the resident/surrogate decision maker indicating the desire to be DNR but physician order is pending. Dependent lividity, rigor mortis, decapitation, or transection. (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	Review of Inservice sheet dated February 28, 2024, revealed Objective if resident is found pulseless or without respirations, do not leave the resident alone, call out for help if necessary, instruct someone to call 911, and start CPR. Use an AED as soon as possible if one is available. If no AED is available, continue compressions and breaths for 2 Minutes then recheck pulse until EMS arrives. Review of Resident R1's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses of type 2 Diabetes Mellitus (a condition results from insufficient production of insulin, causing high blood sugar). Review of Resident R1's clinical record revealed a February 2, 2024, physician's order for Full Code, indicating Resident R1's intention to have FULL treatment which includes attempt resuscitation, CPR. Review of facility documentation submitted to the State Agency on February 17, 2024, revealed that Resident R1 was found unresponsive when Licensed nurse, Employee E6, walked into the resident's room to obtain a blood sugar. Employee E6 went and checked the code status and looked in the computer under the first name and looked at the incorrect resident whose was coded as Do not Resuscitate. Employee informed the Nursing Supervisor (RNS), Employee E30, that the code status of Resident R1 was DNR. The Acting DON (Director of Nursing), Employee E3, was informed by Employee E30. The Acting DON, Employee E3 reported to the PA (Physician Assistant) Employee E7, that Resident R1 was unresponsive and was a DNR. The PA, Employee E7 reported to the Acting DON that resident R1 was a Full Code. At that time the Acting DON called a code, CPR was initiated and 911 (Emergency Medical Services) was called. The paramedics took over CPR and were able to obtain a pulse and transported the resident to the hospital. Interview with Licensed nurse, Employee E6, on February 28, 2024, at 12:05 p.m. confirmed that she was on duty on February 14, 2024, when she found Resident R1 unresponsive. She also confirmed that she had looked up the wrong resident in the computer using a first name because she could not remember Resident R1's last name at the time. Employee E6 also confirmed that she left the resident's room to use the computer and to get the supervisor (RNS), Employee E30, and that she told him that Resident R1 was a DNR. Employee E6 said that the RNS assessed the resident who was still unresponsive, and that it was later that the PA (Employee E7) said that Resident R1 was a full code, and then they started CPR. The Acting DON called 911 and did the paperwork. Employee E6 could not confirm the timing, stating that everything happened so fast, and that if she knew the resident was a Full Code she would have started CPR immediately. Telephone interview with Nurse aide, Employee E31, on February 28, 2024, at 5:50 p.m. confirmed that she was on duty on February 14, 2024, when Licensed nurse, Employee E6, reported to her that Resident R1 was unresponsive. She stated that she was in Resident R1's room giving care to Resident R1's roommate when Licensed nurse, Employee E6 made this report. Nurse aide, Employee E31 also stated that the Licensed nurse, Employee E6, asked her to provide after care to Resident R1. Employee E31 further stated that the Licensed Nurse, Employee E6 removed Resident R1's Foley (indwelling urinary) catheter, and Employee E31 said she cleaned the resident up and changed her gown to make her presentable to the family if they came to view the resident's body. Employee E31 stated that it was about 15 minutes from the time she was told that Resident R1 was unresponsive and when the code was called, and CPR was started. She said she remembered this because after the incident someone had asked this question and appeared upset when she said 15 minutes, she did not recall who this was. She said that she remained in the room to help with the code until 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 - Few	Telephone interview with Employee E30, RNS, on February 28, 2024, at 5:40 p.m. confirmed that he was the supervisor on duty on February 14, 2024, when Resident R1 was found unresponsive by Employee E6, and that Employee E6 had reported to him that the resident was a DNR, and that he called the Acting DON before he went to Resident R1's room to assess her. He said it was a short while later that the Acting DON and PA came to the floor to report that Resident R1 was a Full Code, and that the Acting DON had called a code and they began CPR. Interview on February 28, 2024, at 11:05 a.m. with Employee E3, ADON, who was Acting DON on February 14, 2024, confirmed that she was on duty when Employee E30, RNS called her about Resident R1 being unresponsive and that she was a DNR. She stated that she saw the PA, Employee E7, and told her about Resident R1 being unresponsive and a DNR, and that the PA checked and found that the resident was a Full Code. The ADON stated that she and the PA went to the first floor, and that she stopped in the lobby to have the receptionist call a code. She said that once the team started CPR, she called 911 and started the paperwork for transfer to the hospital. The ADON confirmed that it was about 10:50 a.m. the time she put on the report when she was talking to the PA when they realized that Resident R1 was a Full Code. Interview with the PA, Employee E7, confirmed that she was on duty on February 14, 2024, when Employee E3, ADON reported to her that Resident R1, who was a DNR, was found unresponsive. She stated that she looked it up in the computer because she thought the resident was a Full Code, and when she confirmed that Resident R1 was a full code they went down to the first floor to call a code. When asked what time this was, she said it was shortly after she got there for the day, and that she signed in at the front desk that morning. The Nursing Home Administrator, Employee E1 was able to pull the camera for the first floor which showed the Licensed nurse, Employee E6 and RNS, Employee E30 entering Resident R1's room at 10:41 a.m., and the nurse getting the crash cart at 10:55 a.m., leaving 14 minutes from the time the RNS found the resident unresponsive and when the code was called and CPR was started. A review of the Resident R1's clinical record revealed a nursing note by RNS, Employee E30, dated February 14, 2024, indicating call placed to hospital ER Nurse who indicated that Resident R1 had expired at 11:58 a.m. Interview conducted with the NHA, DON and ADON on February 28, 2024, at 11:25 a.m. confirmed that there was a delay in starting CPR due to Licensed nurse, Employee E6 misidentifying Resident R1's code status and proceeding as a DNR when the resident was a Full Code. Based on the above findings, an Immediate Jeopardy was identified to the Nursing Home Administrator on February 28, 2024 at 1:48 p.m. for failure to perform CPR immediately for a resident who had elected to be Full Code. The Immediate Jeopardy template was provided to the Administrator and Director of Nursing on February 28, 2024, at 1:53 p.m., and an immediate action plan was requested. The facility submitted an action plan on February 28, 2024, at 5:55 p.m. that included the following actions: -DON determined that resident was a full code, CPR was inititiated and 911 was called 10:55 a.m. The paramedics arrived at 11:07 a.m. and continued CPR. Resident had a pulse when she left the building. Resident was transported to the hospital. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Social Services completed a house audit of Code status and ensure medical reflects current status. -ADON/designee audited crash carts to ensure all equipment is available per community policy. -Payroll coordinator to conduct an audit of all licensed staff for current CPR certification. -LPN was suspended pending investigation. ADON/designee educated licensed nurses on CPR policy-to include resident identification and following resident code status wishes. -Payroll coordinator by Nursing Home Administrator was educated on ensuring Licensed nurse have a current CPR certification. -DON/designed will completed [NAME] codes over 2 shifts-[DATE]; ,d+[DATE] and ,d+[DATE]. [DATE], , d+[DATE]; Ad hoc QAPI (Quality Assurance Program Improvement) completed [DATE] via phone and [DATE] interdisciplinary team ad hoc completed. -DON/designee will monitor code status for all new admissions and for any order changes -ADON/designee will monitor crash cart checks to ensure crash carts are being monitored. -ADON/designee will complete Mock codes three times a week for 4 weeks to determine competency and any need for further education. -The results of the audits will be forwarded to the faciltiy QAPI committee for further review and recommendations. -[DATE] Licensed staff per our policy were re-educated to perform CPR on residents who have elected such services by performed until EMS arrives and assumes responsibility for the resident. Licensed staff were educated on where to find advanced directives and CPR status. -Ad hoc review of CPR policy. The Immediate Jeopardy was lifted on February 29, 2024, at 4:11 p.m. when it was confirmed that the facility provided nursing staff with education regarding providing CPR in accordance with residents' advanced directives, and the facility's policy, and completed [NAME] Code drills to ensure that licensed nurses were prepared to respond to situations that required CPR. Any remaining staff were scheduled to receive the education prior to the start of their next shift. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 201.18(e)(3) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38735 Based on a review of clinical records, facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility related to ensuring that Cardio Pulmonary Resuscitation (CPR) was provided in accordance with established facility policy for one of eleven residents reviewed (Resident 207), which resulted in an Immediate Jeopardy situation. Findings include: Review of the job description for the Nursing Home Administrator (NHA) revealed under positron summary that the NHA is to lead and direct the overall operations of the nursing faciltiy in accordance with the community policies and procedures, customer and resident needs, and both State and Federal guidelines. To maintain excellent care for the residents/patients and achieve the faciltiy's business objective. Monitoring each department's activities, ensuring that each department attains and maintains compliance with State and Federal requirements. Review of the job description for the Director of Nursing revealed under position summary that as the Director of Nursing it is your responsibility to organize, develop and direct the overall operations of the Nursing Services Department in accordance with current federal, state and local standards, guidelines and regualtion that govern the facility. The Director of Nursing is to work directly with the Administrator and the Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times. Review of Resident R1's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses of type 2 Diabetes Mellitus (a condition results from insufficient production of insulin, causing high blood sugar). Review of Resident R1's clinical record revealed a February 2, 2024, physician's order for Full Code, indicating Resident R1's intention to have FULL treatment which includes attempt resuscitation, CPR. Review of facility documentation submitted to the State Agency on February 17, 2024, revealed that Resident R1 was found unresponsive when Licensed nurse, Employee E6, walked into the resident's room to obtain a blood sugar. Employee E6 went and checked the code status and looked in the computer under the first name and looked at the incorrect resident whose was coded as Do not Resuscitate. Employee informed the Nursing Supervisor (RNS), Employee E30, that the code status of Resident R1 was DNR. The Acting DON (Director of Nursing), Employee E3, was informed by Employee E30. The Acting DON, Employee E3 reported to the PA (Physician Assistant) Employee E7, that Resident R1 was unresponsive and was a DNR. The PA, Employee E7 reported to the Acting DON that resident R1 was a Full Code. At that time the Acting DON called a code, CPR was initiated and 911 (Emergency Medical Services) was called. The paramedics took over CPR and were able to obtain a pulse and transported the resident to the hospital. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed nurse, Employee E6, on February 28, 2024, at 12:05 p.m. confirmed that she was on duty on February 14, 2024, when she found Resident R1 unresponsive. She also confirmed that she had looked up the wrong resident in the computer using a first name because she could not remember Resident R1's last name at the time. Employee E6 also confirmed that she left the resident's room to use the computer and to get the supervisor (RNS), Employee E30, and that she told him that Resident R1 was a DNR. Employee E6 said that the RNS assessed the resident who was still unresponsive, and that it was later that the PA (Employee E7) said that Resident R1 was a full code, and then they started CPR. The Acting DON called 911 and did the paperwork. Employee E6 could not confirm the timing, stating that everything happened so fast, and that if she knew the resident was a Full Code she would have started CPR immediately. Telephone interview with Nurse aide, Employee E31, on February 28, 2024, at 5:50 p.m. confirmed that she was on duty on February 14, 2024, when Licensed nurse, Employee E6, reported to her that Resident R1 was unresponsive. She stated that she was in Resident R1's room giving care to Resident R1's roommate when Licensed nurse, Employee E6 made this report. Nurse aide, Employee E31 also stated that the Licensed nurse, Employee E6, asked her to provide after care to Resident R1. Employee E31 further stated that the Licensed Nurse, Employee E6 removed Resident R1's Foley (indwelling urinary) catheter, and Employee E31 said she cleaned the resident up and changed her gown to make her presentable to the family if they came to view the resident's body. Employee E31 stated that it was about 15 minutes from the time she was told that Resident R1 was unresponsive and when the code was called, and CPR was started. She said she remembered this because after the incident someone had asked this question and appeared upset when she said 15 minutes, she did not recall who this was. She said that she remained in the room to help with the code until the paramedics arrived. Telephone interview with Employee E30, RNS, on February 28, 2024, at 5:40 p.m. confirmed that he was the supervisor on duty on February 14, 2024, when Resident R1 was found unresponsive by Employee E6, and that Employee E6 had reported to him that the resident was a DNR, and that he called the Acting DON before he went to Resident R1's room to assess her. He said it was a short while later that the Acting DON and PA came to the floor to report that Resident R1 was a Full Code, and that the Acting DON had called a code and they began CPR. Interview on February 28, 2024, at 11:05 a.m. with Employee E3, ADON, who was Acting DON on February 14, 2024, confirmed that she was on duty when Employee E30, RNS called her about Resident R1 being unresponsive and that she was a DNR. She stated that she saw the PA, Employee E7, and told her about Resident R1 being unresponsive and a DNR, and that the PA checked and found that the resident was a Full Code. The ADON stated that she and the PA went to the first floor, and that she stopped in the lobby to have the receptionist call a code. She said that once the team started CPR, she called 911 and started the paperwork for transfer to the hospital. The ADON confirmed that it was about 10:50 a.m. the time she put on the report when she was talking to the PA when they realized that Resident R1 was a Full Code. The Nursing Home Administrator, Employee E1 was able to pull the camera for the first floor which showed the Licensed nurse, Employee E6 and RNS, Employee E30 entering Resident R1's room at 10:41 a.m., and the nurse getting the crash cart at 10:55 a.m., leaving 14 minutes from the time the RNS found the resident unresponsive and when the code was called and CPR was started. (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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview conducted with the NHA, DON and ADON on February 28, 2024, at 11:25 a.m. confirmed that there was a delay in starting CPR due to Licensed nurse, Employee E6 misidentifying Resident R1's code status and proceeding as a DNR when the resident was a Full Code. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position, contributing to the Immediate jeopardy situation. Refer to F678. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 201.18(b)(3) Management 28 Pa Code 201.18(e)(1) Management