STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525305	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol Lakes Health Center	333 W Main St Madison, WI 53703

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 honor a resident's advanced directive of choosing to have basic life support measures provided including cardiopulmonary resuscitation (CPR) for 1 of 1 resident (R34) reviewed during a closed record review. R34, whose advanced directive indicated he chose to have basic life support performed in the event of an emergency situation, was found unresponsive by facility staff. R34's activated health care power of attorney (HCPOA) was contacted, stated he did not wish CPR to begin, and facility staff members were instructed not to begin CPR on R34. R34 passed away at the facility. The facility's failure to provide basic life support, including cardiopulmonary resuscitation, to a resident who wished to be a full code, created a finding of immediate jeopardy that began on [DATE]. Surveyors notified NHA A (Nursing Home Administrator) of the immediate jeopardy on [DATE] at 3:01 PM. The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a severity/scope of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. This is evidenced by: Facility policy titled, Cardio Pulmonary Resuscitation (CPR) - SNF (Skilled Nursing Facility), created in 02/2015 and last revised in 10/2023, states in part: Policy: It is the policy of the Company to initiate cardiopulmonary resuscitation on any resident suffering from cardiac or respiratory arrest unless (1) otherwise specified by a physician's order made consistent with the resident's expressed wishes (directly or through legal decision-maker), (2) in the presence of obvious clinical signs of irreversible death, e.g., rigor mortis, decapitation, transection, decomposition, or dependent lividity, or (3) initiating CPR could cause injury or peril to the rescuer. Procedure: 1. The facility will not implement a facility-wide ?no CPR' policy to ensure that all residents have the ability to exercise their right to formulate an advanced directive. 2. Upon admission to the facility, admission orders will be completed including the patient's wishes as expressed in their Advanced Directives, resuscitation status and life sustaining treatment options. 4. The resident's Advance Directives and related physician's orders will be reviewed quarterly at the resident's Care Conference or upon significant change in condition. Resident and/or their legal decision-maker shall be asked whether the current orders are consistent with the resident's wishes. If changes or clarifications are requested, the attending physician shall be contacted to update orders to reflect such changes. Any changes shall be clearly documented by completion of a new life sustaining treatment form (national or state) or Advanced Directive. Edits or discontinuation to an existing life sustaining treatment options form or Advanced Directive is unacceptable. 6. If the resident, or legal decision-maker if applicable, desires full resuscitation efforts, the following procedure will be followed: a. The staff person finding the resident in need of CPR will verify if the resident is a full CPR. Resident without a ?DNR' (do not resuscitate) order is considered ?Full CPR'. b. The staff person will loudly call for help and activate bedside or bathroom call system, if available, start CPR and simultaneously, alert somebody to call 911 and get a Licensed Nurse (if first responder is not a nurse). c. The Licensed Nurse will respond ?stat' with the Emergency Cart and AED (automated external defibrillator) in states where AEDs are applicable, and help/direct resuscitation measures. d. The person calling 911 will request Advanced Life Support (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	Assistance and say ?CPR in progress. e. Every available Licensed Nurse in the health center will respond to the Code ?stat', and assist in emergency measures including checking of vital signs, pulse ox, oxygen, finger stick blood sugar, etc. f. The Licensed Nurse will delegate responsibilities as needed. g. The CNAs assigned to the section of the involved resident will follow directions from the Licensed Nurse. h. CPR is to be continued until Advanced Life Support personnel arrive and take over or the resident revives.R34 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia (neurogenerative disorder resulting in motor issues, such as tremors, muscle stiffness, and postural instability with involuntary, uncontrollable body movements), neurocognitive disorder with Lewy Bodies (progressive dementia affecting attention, cognition, and visual perception), type 2 diabetes mellitus, depression, chronic kidney disease - stage 3 (moderate kidney damage), and dysphagia - oropharyngeal phase (difficulty initiating swallowing). R34's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] indicated R34 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating R34 was severely cognitively impaired. R34's HCPOA was activated on [DATE] and named his son as the POA. R34's physician orders indicated that R34 had chosen to be a full code. R34 had elected I do want CPR on the facility's Resident Advance Directive Regarding Cardiopulmonary Resuscitation form. R34 had signed the form on [DATE], upon admission to the facility. The form had a witness signature and was also signed by NP J (Nurse Practitioner). R34's Care Conference notes on [DATE] state the following, in part: A. General Data. 5. What are the Resident's Goals and Desired Outcomes? [R34] is here for long term care. Son, [HCPOA F], wanted to talk to [R34] in person about CPR status which is currently full code. [HCPOA F] will update us if this is to change. R34 was seen by his primary care provider (PCP), MD I (Medical Doctor), on [DATE]. Notes from the visit state the following, in part: .Goals of care, counseling/discussion: Discussed with [HCPOA F] that while [R34] is stable at this time, he is at risk for acute events that could change his health trajectory with infections (especially aspiration) being of concern. [HCPOA F] notes that at this time his father is a ?full code' and understands the implications of that. He would like to try to discuss with his father more at an upcoming visit. I did advise [HCPOA F] that as activated HCPOA he can certainly make a substituted judgment about medical interventions, based on his knowledge of his father's historical preferences as well as information about [R34's] prognosis. At this time he elects to keep [R34] a full code. I did advise him in the event of cardiac or pulmonary arrest, [R34's] prognosis would be grave even with interventions, and it would be unlikely he would return to baseline. [HCPOA F] will let us know if he decides to adjust code status. On [DATE], the facility completed a Significant Change in Status Assessment MDS for R34 due to a noted decline. The facility also held a Care Conference. R34's Care Conference notes on [DATE] state the following, in part: A. General Data. 5. What are the Resident's Goals and Desired Outcomes? [R34] is here for long term care. Son, [HCPOA F] spoke to [R34] in the meeting about CPR status which is currently full code. The possible complications of CPR were talked about and [R34] states he would still like to be full code at this time. No changes made. R34's Progress Note on [DATE] at 1:14 PM, written by LPN C (Licensed Practical Nurse) states the following, in part: Son [HCPOA F] was here this morning to see [R34] one more time before heading home out of state. [HCPOA F] states that since he has been able to spend a few days with his dad, he has noticed that [R34] wants to sleep/nap more, has less interest in eating and just generally more tired/weak. [HCPOA F] states that he and [R34] talked yesterday and in the past, [R34] was not receptive to Hospice but now states that he thinks it may be time to look into it. Writer let [HCPOA F] know that NP will be updated and will likely call him to touch base before putting a referral in. [HCPOA F] is okay with this and states he will be available by phone as they are driving home. R34 was seen by NP J on [DATE]. Notes from the visit state the following, in part: .Code Status: Full Code. Assessment & Plan: .I am concerned that [R34] continues to be more frail with declining health and mobility concerns. After discussions with [R34] as well as his son and aHCPOA, [HCPOA F], they are both interested for [Hospice Agency] referral for hospice. Will order this today (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and update PCP as well. R34's Progress Notes on [DATE] state the following: 11:30 AM - (Writer: Social Services): Writer called [Hospice Agency] re: referral for hospice services. [Hospice Agency] to follow up with HCPOA [HCPOA F] to coordinate visit date and time. Per [Hospice Agency] follow up, assessment arranged for 2/3 with arrival between 10-11 am. HCPOA [HCPOA F] to be via phone. 5:36 PM - (Writer: RN D (Registered Nurse)): At 15:45 hrs (hours) (3:45 PM), aide [initial] notified writer about resident's condition. Writer rushed to resident's room et (and) found him unresponsive with his mouth half-way opened while laying in bed. No breathing was noted et no pulse could be felt. No movement of his body part was noticed. Skin is semi-pale et very minimally warm. CPR declined per son following conversation with NP [NP J] at the time. [MD I's] office was notified at 16:25 hrs (4:25 PM) et she (M.D) returned call at 16:45 hrs (4:45 PM). She plans to come in to the facility soon afterwards. 5:53 PM - (Writer: LPN C): [MD I] came in at 1735 (5:35 PM) and pronounced [R34's] death at 1740 (5:40 PM). Call placed to medical examiners office and requested information was given with no further follow up needed and states the MD can put ?natural causes' on the certificate.[NP J] NP was here at time of change of condition and called son/AHCPOA, [HCPOA F] to update him and see if he wanted us to start CPR and [HCPOA F] stated no. On [DATE] at 2:04 PM, Surveyors interviewed NP J. NP J indicated R34 had a history of Parkinson's disease and dysphagia. NP J indicated he had discussed the possibility of R34 starting hospice with HCPOA F in [DATE] and R34's PCP had discussed starting hospice in [DATE] due to R34's ongoing disease progression, but HCPOA had not been ready for that yet. NP J indicated he had seen R34 on [DATE] for a routine compliance visit and R34 and HCPOA F had indicated they were ready to move forward with a hospice referral, so NP J wrote an order for this.NP J indicated on [DATE], a CNA had been doing rounds, saw that R34 was unresponsive, and went to the nurse on duty. The nurse went in and assessed R34. NP J had been walking down the hallway and ran in to assess R34. NP J indicated he listened to his chest for two minutes and noted no response to a sternal rub or physical stimulation. NP J noted R34 had fixed pupils. NP J indicated he called HCPOA F right away because they had talked about R34's hospice transition. NP J indicated at the time, R34 was still a full code, but his son was planning on switching him to a DNR with the hospice transition. Surveyor asked if HCPOA F said he wanted R34 changed to a DNR or if he only wanted him to get a hospice referral? NP J indicated HCPOA F had seen R34 declining and the general thought was that he was planning on changing him to a DNR. HCPOA F never verbally discussed changing R34's code status with NP J. HCPOA F had only indicated that he wanted R34 to start hospice. NP J indicated hospice had not seen R34 for an evaluation yet, but the initial visit was going to be within 24 hours. Surveyor asked NP J if someone can be a full code on hospice. NP J said no. NP J indicated if HCPOA F had said yes to doing CPR, NP J would definitely have started it. Surveyor asked if someone's code status says full code and has not been changed, should you perform CPR? NP J said yes. Of note: R34's hospice evaluation was scheduled for [DATE], not within 24 hours. Additionally, a resident on hospice can elect to be a full code. On [DATE] at 3:57 PM, Surveyor interviewed RN G. RN G indicated he notes residents' code statuses at the beginning of each shift. RN G indicated if he found a resident who was pulseless and not breathing, he would assess the resident, call for help, and begin CPR if the resident was a full code. If the resident was DNR, he would not initiate CPR. RN G indicated a CNA can initiate CPR on a resident if they have training for it. RN G indicated he was working with R34 on [DATE]. RN G indicated R34 was a full code and had been declining - there had been discussions about transitioning him from a full code to hospice. RN G indicated he had been in another room providing cares and was informed that R34 was unresponsive. RN G entered R34's room and NP J came in behind him. RN G began assessing R34. RN G indicated NP J said he would call R34's son while RN G assessed R34 because he did not think HCPOA F would want CPR initiated.RN G noted R34 was laying down with his mouth halfway open and wasn't breathing. RN G said R34's name three times and he did not respond. RN G tried to feel R34's carotid pulse and did not see his chest rise. RN G indicated he told NP J that R34 is a full code and needs CPR initiated. RN G indicated NP J was on the phone with HCPOA F and told him he (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hadn't seen R34's chest rise or felt a pulse. NP J then told RN G HCPOA said not to start CPR, so he didn't.RN G indicated if he had been in R34's room by himself, he absolutely would have initiated CPR right away, but he had been told not to start it. RN G confirmed R34 had not transitioned to hospice yet and had not been a DNR at the time of this incident.On [DATE] at 4:07 PM, Surveyor interviewed CNA H (Certified Nursing Assistant) and asked what she would do if a resident was found pulseless and not breathing. CNA H indicated she would contact a nurse or supervisor on her walkie talkie. CNA H indicated she could then start CPR if the resident was a full code because she's CPR certified. If the resident was a DNR, she would wait for the nurse to arrive. CNA H indicated she tries to know the residents' code statuses when she starts her shift. The code statuses can also be looked up at the nurses' station.On [DATE] at 4:15 PM, Surveyor interviewed RN D and asked what she would do if a resident was found pulseless and not breathing. RN D indicated she would verify that there was no pulse and breathing and would have someone check on the resident's code status. If the resident was a full code, she would start CPR until more help arrived. If the resident was a DNR, she would stay with him or her, verify this, assess the resident, and then follow up with the physician or POA, as applicable. RN D indicated the most up-to-date code status information is in the electronic chart. The code status is on the resident's dashboard page as well as in the orders. RN D indicated CNAs with a red sticker on their name badge can start CPR, as they are CPR certified, but they would then have to get a nurse into the room to assess the resident.On [DATE] at 10:58 AM, Surveyor interviewed CNA E and asked what he would do if a resident was found pulseless and not breathing. CNA E indicated he would immediately notify a nurse. CNA E indicated most of the residents this happens to are on hospice, so it wouldn't be an issue. Surveyor asked if a resident on hospice can be a full code. CNA E indicated he wasn't 100% sure and would verify this with a nurse. CNA E indicated he usually knows the code status because he works with residents regularly, but could look it up in the chart if he didn't know. CNA E indicated he was CPR certified and could start compressions if the resident was a full code and then would call out for a nurse to come in.CNA E indicated he was working with R34 on [DATE]. CNA E indicated he looked at R34 during the last hour and he was fine and then went back into his room to get him up for dinner, noticed that he wasn't responding, and notified RN G. CNA E indicated he did sternal rubs, looked at the code status, and noted that R34 was a full code. CNA E indicated RN G wanted to check on the code status with the nursing supervisor. CNA E asked RN G if he should start chest compressions but came to the conclusion that R34 was not a full code because he was never told to start compressions. CNA E indicated he could not remember who told him not to start compressions.On [DATE] at 11:55 AM, Surveyor interviewed LPN C. NHA A had referred Surveyor to LPN C because the facility's Director of Nursing was on vacation during the survey. LPN C is a unit manager. Surveyor asked what the process is if a nurse finds a resident pulseless and not breathing. LPN C indicated the nurse should find out the code status. If the resident is a full code, CPR should be initiated. If the resident is a DNR, CPR would not be initiated. LPN C indicated code statuses can be found on the resident's face sheet in the physical chart or in the banner in the resident's electric chart. Surveyor asked what a staff member would do if they were in a room and didn't know the code status. LPN C indicated they could yell out for help to have someone look or they could run to find out. LPN C indicated DNR bracelets are available for residents on hospice in their chart, but they are not physically put on. LPN C indicated CNAs can initiate CPR if they are certified; otherwise, the expectation would be to get a nurse.LPN C was present during R34's care conference on [DATE]. LPN C indicated HCPOA F had briefly talked with R34 about his full code status. Code statuses are brought up at every care conference to see if any changes are to be made. LPN C indicated R34 said he'd be willing to talk about it, but no changes were made at that time. After the care conference, HCPOA F was visiting for a few days, had noticed some changes with R34, and decided to get hospice started. As of [DATE], R34 had not been seen by the hospice agency, and they hadn't signed on. R34 had not changed his code status at that point.LPN C was the unit manager on [DATE]. The Activities Director had notified her that R34 has passed away. LPN C indicated nobody (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	had asked her what R34's code status was. LPN C indicated the nurse on the floor was in the room assessing R34 and NP J was in the room on the phone with HCPOA F. LPN C indicated from her understanding, RN G had asked CNA E to get NP J. RN G was still assessing R34 while NP J was on the phone with HCPOA F and RN G was told not to do CPR because HCPOA F did not want it started.Surveyor asked what LPN C's expectation would be for someone who is a full code. LPN C indicated as a unit manager, she would expect CPR to have been started.On [DATE] at 1:00 PM, Surveyor interviewed NHA A and asked what her expectation is for a nurse who finds a resident unresponsive and the resident is a full code. NHA A said, Start CPR.The facility's failure to follow R34's code status identified in his advance directives and not providing cardiopulmonary resuscitation created serious harm, thus leading to a finding of Immediate Jeopardy that began on [DATE]. The facility removed the immediate jeopardy on [DATE], however, the deficient practice continues at a severity/scope of D (potential for more than minimal harm/isolated) as the facility continues to implement the following action plan: A nurse found a resident pulseless and not breathing and sought guidance from the resident's onsite APP (advance practice provider), who directed the nurse to hold off CPR until he could reach the activated POA. Residents who have documented wishes to have CPR have the potential to be affected.Licensed nurses to be reeducated on CPR policy and procedures and to perform CPR based on documented wishes regardless of direction of advanced care provider onsite or preference of activated POA. LN (licensed nurse) education started on [DATE] at 4:30 and will continue until all nurses reeducated prior to their next scheduled shift. On [DATE] CPR policy reviewed with Medical Director and Nurse Practitioner and determined it to meet current standards of practice. CPR will be initiated on a pulseless, non-breathing individual regardless of activated power of attorney's direction if CPR status change has not been documented. Also determined that code status will be reviewed with residents or activated POAs choosing CPR at each MD and APP compliance visits and with change of condition to ensure documented wishes are current. This discussion included reeducation/confirmation of provider understanding of residents' rights to choose to be a full code and to follow facility policy accordingly. This education to be provided to other facility providers by the Medical Director.Nurse managers will perform mock drills to ensure staff understand what actions to take when finding a resident pulseless and not breathing 5x/week for 4 weeks with immediate education provided as needed. Results of the audits will be analyzed to identify any trends and reviewed at quarterly QAPI meetings for further recommendations.