STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676031	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Nursing and Rehabilitation	4343 Oak Grove Blvd San Angelo, TX 76904

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45399 Based on interviews and record reviews the facility failed to ensure the resident's had the right to be informed of the risks, and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 3 of 20 residents (Resident #34, Resident # 47, Resident#260) reviewed for resident rights . The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #34 prior to administering Zoloft, an antidepressant used to treat depression. The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #47 prior to administering Zoloft, an antidepressant used to treat obsessive compulsive disorder. The facility also failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #260 prior to administering Depakote, an anticonvulsant used to treat anxiety. This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party. Findings include: Record review of Record review of Resident #34's face sheet revealed admitted [DATE] with diagnoses of major depressive disorder (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life), Type 2 Diabetes Mellitus (long term condition where body has trouble controlling blood sugars), and Schizoaffective disorder (mental health condition, including schizophrenia and mood disorder symptoms). He was [AGE] years of age. Record review of Resident #34's quarterly MDS, dated [DATE], indicated he had a BIMS score of 15, which indicated he was cognitively intact. The MDS also indicated Resident #34 was receiving antipsychotic and antidepressant medications on a routine basis. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #34's care plan dated 2/9/24 indicated, in part: Focus: resident has behavior problems. Goal: The resident will have fewer episodes through review date. Intervention: Administer medications as ordered by physician. Monitor/document side effects and effectiveness. Record review of Resident #34's medication profile dated 02/23/24 indicated in part: Zoloft, 50 MG, Give 1 tablet by mouth at bedtime for depression. Record review of Resident #34's clinical records revealed no consent on file prior to the facility administering Zoloft for depression. Record review of the February 2024 Medication administration record revealed Zoloft were was administered to rResident #34 on 2/23, 2/24, 2/26, 2/27, and 2/28 without consent. Record review of Record review of Resident #47's face sheet revealed admitted [DATE] with dysphagia (swallowing difficulties), epilepsy (disorder of brain causing seizures), obsessive compulsive disorder (uncontrollable thoughts and repetitive behaviors), and mild intellectual disabilities (deficits in intellectual functioning). He was [AGE] years of age. Record review of Resident #47's quarterly MDS, dated [DATE], indicated he had a BIMS score of 99, which indicated he was unable to answer questions. The MDS also indicated Resident #47 was receiving hospice services. Record review of Resident #47's care plan dated 2/12/24 indicated, in part: Focus: resident had impaired cognitive function or impaired thought process related to developmental delays. Goal: The resident will communicate basic needs on daily basis. Intervention: Administer medications as ordered by physician. Monitor/document side effects and effectiveness. Record review of Resident #47's medication profile dated 02/20/24 indicated in part: Zoloft, 50 MG, Give 1 tablet by mouth at bedtime for OCD (obsessive compulsive disorder). Record review of Resident #47's clinical records revealed no consent on file prior to the facility administering Zoloft for OCD (obsessive compulsive disorder). Record review of the February 2024 Medication Administration Record revealed Zoloft were was administered to rResident #47 every day from 2/20/24 to 2/28/24 without consent. Record review of Record review of Resident #260's face sheet revealed admitted [DATE] with Chronic obstructive pulmonary disease (constriction of airway, difficulty breathing), chronic hypoxic respiratory failure (not enough oxygen in blood), chronic renal failure (kidney damage resulting in inability to filter blood). He was [AGE] years of age. Record review of Resident #260's care plan dated 2/26/24 indicated, in part: Focus: resident had impaired cognitive function or impaired thought process. Goal: The resident will maintain current level of cognitive function. Intervention: Administer medications as ordered by physician. Monitor/document side effects and effectiveness. Record review of Resident #260's medication profile dated 02/23/24 indicated in part: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Depakote, 125 MG, Give 1 tablet by mouth twice a day for anxiety. Record review of Resident #260's clinical records revealed no consent on file prior to the facility administering Depakote for anxiety. Record review of the February 2024 Medication Administration Record revealed Depakote were was administered to rResident #260 every day from 2/23/24 to 2/28/24 without consent. Interview on 2/28/24 at 4:37 PM, DON stated that she looked for the consents for residents #34, #47, and #260. DON stated that she was unable to find the consents for the above-mentioned medications. DON stated that as of yesterday (2/27/24), all consents had been scanned into the residents' electronic medical charts. DON stated that since the consents are not in the electronic charts, they did not get signed. DON stated that it is the responsibility of the admission nurse or the nurse who takes the order to get the consent signed prior to medication administration. DON stated that it is her responsibility to check all admissions to ensure consents were obtained. The DON stated that the consenting process is important because these medications can have major side effects that the resident should be informed of prior to receiving them. Record review of the facility's policy dated July 2022, titled Psychotropic Medication Use indicated, in part: 1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and our are subject two to prescribing, monitoring, and review requirements specific to psychotropic medications: Antipsychotics, Antidepressant, Anti-anxiety Medications and hypnotics. 3. Resident and representative have the right to decline treatment with psychotropic medications. The staff and physicians will review with the resident/representative, the risks related to not taking the medication as well as appropriate alternative.

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on interview and record review, the facility failed to protect residents' rights to formulate an advance directive for 1 (Resident #161) of 17 residents reviewed for advanced directives. The facility failed to ensure there was a system in place to assess code status adequately and accurately during the admission process after regular business hours, on weekends, and on holidays, resulting in Resident #161's code status not being assessed correctly during her admission to the facility on hospice services [DATE] at 8:00 pm. Resident #161 had chosen Do Not Resuscitate status. This failure also resulted in Resident #161's code status remaining listed as Full Code when she became unresponsive on [DATE]. These failures resulted in Hospice RN M pronouncing the resident deceased at 3:40 pm and LVN C calling 911 and initiating CPR on [DATE] at approximately 4:15 pm after being unable to locate Resident #161's DNR form. An Immediate Jeopardy (IJ) was identified on [DATE] at 3:59 pm and the IJ Template was provided to the facility Administrator. While the Plan of Removal (POR) was accepted on [DATE] at 3:05 pm and the immediacy was removed on [DATE] at 5:41 pm, the facility remained out of compliance at a scope of isolated at a level of no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed the residents at risk of not having their wishes known, respected, and implemented in an emergency. The findings included: Review of Resident #161's Admission Record revealed she was an [AGE] year-old female originally admitted to the facility [DATE] with a most recent admitted [DATE]. She had admission diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), moderate malnutrition, breast cancer, chronic pain, and atrial fibrillation (abnormal heart rhythm). Her code status was listed as Full Code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures would be provided to keep them alive). Review of Resident #161's MDS list revealed that at the time of her [DATE] admission, no comprehensive MDS assessment had been initiated. Review of Resident #161's Hospice Clinical Chart revealed that during her intake interview and assessment on [DATE] at 3:52 pm, the resident was a full code but requested DNR paperwork (there was no DNR form located in the resident's EHR during record review) be given to her and her family to fill out. Review of Resident #161's Hospice admission orders dated [DATE] revealed no mention of code status. Review of Resident #161's Admission Assessment/Baseline Care Plan Summary, initiated [DATE] and signed [DATE], revealed in Section O Code Status that she was a DNR. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #161's Physician's Progress Notes revealed no mention of code status in the admission note. Review of Resident #161's care plan dated [DATE] revealed Problem: I have chosen DO NOT RESUSCITATE status. Review of Resident #161's Order Listing Report revealed no order for code status. Review of facility's handwritten 24-hour report log for dates [DATE] and [DATE] revealed Resident #161 was reported as being a DNR. The 24-hour report log sheet dated [DATE] stated Resident #161 re-admit, COPD, moderate protein-calorie malnutrition, hospice. The facility was unable to provide the 24-hour report log for [DATE]. In a phone interview on [DATE] at 2:53 PM with the Hospice Administrator she stated that the hospice company never received a copy of Resident #161's DNR from the family as they were told that the family was going to be providing a copy to the nursing home to keep on file. She stated that the hospice company was told that the family had given a copy of the DNR to facility LVN D on Friday [DATE] when the resident was admitted to the facility and that LVN D either had or was going to enter it into the computer system. She stated that the resident had been living in an assisted living facility but was hospitalized and had a significant decline after being discharged from the hospital and the family opted for her to be placed on hospice services and be admitted to the nursing facility. She stated that when all the hospice paperwork was signed by the family, the family kept the DNR paperwork and assured the hospice employee that they would give the nursing home a copy. She stated that the hospice company offered the family a counseling session with their Social Worker to discuss the DNR paperwork and their options, but the family declined because there was already a DNR in place. The Hospice Administrator stated that on [DATE] a facility nurse called the hospice to notify the Hospice RN M that the resident had passed away. She stated that, according to the notes and discussions she had after the incident with Hospice RN M, Hospice RN M arrived at the facility and pronounced a time of death for Resident #161 at on [DATE] at 3:40 PM. She stated that the facility nurse could not locate the DNR and instructed someone to call 911 and they (facility staff) began chest compressions. In an interview on [DATE] at 3:30 PM with LVN C she stated she called 911 at 4:11 PM on [DATE]. She stated she called 911 after about 30 minutes of searching the facility for a copy of Resident #161's DNR after the she had called hospice to notify them that the resident had expired, and the hospice nurse had already pronounced a time of death. She stated that after the hospice nurse pronounced the resident, she (LVN C) realized she had not verified the resident's code status and when she went to check she found there was no DNR on file for the resident. She stated that she should have verified the code status before calling hospice to pronounce. LVN C stated the resident was on hospice for comfort measures but was listed as a full code was her understanding. LVN C stated that Resident #161's MPOA told her that she had given a copy of the DNR to LVN E on the night before the resident passed away ([DATE]). She stated that there were several family members in the room, including the MPOA, when the resident passed and after hospice pronounced a time of death the family left the facility. She stated that whoever received records for the resident's admission would be responsible for making sure there was a DNR on file. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 10:30 AM with Social Worker, he stated that his role in the code status process was to have a Code Status Discussion with the resident or their representative within 48 hours of admission. He stated the discussion was a simple conversation about what the resident would like to have done if their heart stops while they are a resident, basically CPR or no CPR. He stated he did not get the chance to do the Code Status discussion with Resident #161 due to her admission being after business hours on [DATE] and her passing away on a holiday. He stated he had done a Code Status Discussion with her during her previous admission (,d+[DATE]), and she was a full code. He stated that whoever admitted the resident would have been responsible for getting the copy of the DNR from the family if there was one. He stated if he was the one who takes the DNR from the family he immediately scanned it and uploaded it into the resident's EHR. He stated that he did not have a hard copy DNR book, and he was pretty sure the nurses did not have hard copies of the residents' DNRs either. In an interview on [DATE] at 11:27 AM the Administrator confirmed that facility did not keep hard copies of DNRs on hand in the facility. He stated that all DNRs were kept in resident charts in the facility's EHR and code status was flagged for each resident and that the code status was accessible to all staff with EHR access. In an interview on [DATE] at 04:09 PM ADON stated that when an admission was done, they (staff completing the admission) were supposed to get their own copies of all paperwork including advanced directives. She stated that Resident #161 was a hospice resident, and she feels like they should have provided the facility with the DNR. She stated that the Admission/Readmission Evaluation in the EHR can be initiated by one nurse and finished/signed by a different nurse depending on what time the resident is admitted because of shift change, then the RN signs off on it and there is no way to tell which nurse completed which section. She stated that even if the admission evaluation and the care plan stated that the resident was a DNR, until the facility had the physical copy of the form the resident was considered a full code. In an interview on [DATE] at 04:50 PM LVN D stated he could not remember if he worked [DATE] through [DATE] without looking at a schedule. He stated he did not remember Resident #161 and denied that he was given a DNR for Resident #161 at any time. In a phone interview on [DATE] at 08:55 AM LVN E stated he did not remember Resident #161. He stated the facility had a high amount of resident turnover and if a resident was not long-term it was difficult to remember all the residents. He stated that when he admitted a new resident, he would keep all the admission paperwork at the nurse's desk in a basket for medical records to pick up and scan into the chart. He stated that if he did receive Resident #161's DNR form with her admission paperwork it would have gone into the medical records basket with the other paperwork. He stated that each nurse's station had one of these baskets. LVN E stated all paperwork that the nurses needed scanned into charts went into that basket for medical records. He stated the paperwork in the basket was normally picked up the next day or if it was a weekend, it was picked up Monday morning. He stated that he did not have access to scan documents into resident charts and did not think the other nurses did either. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 11:31 AM Hospice RN M stated she received the call that Resident #161 had passed away at 3:17 pm on [DATE] and it took her a little while to get to the facility. She stated that when she arrived, she assessed the resident and spoke with the family, and she pronounced the resident's time of death as 3:40 pm. She stated that she explained to the family that she would notify the funeral home and make arrangements for the funeral home to contact the family to set up their next steps and that after the family spent a few minutes with the resident they left the facility. She stated that at some point (she was never told what time the call was placed), either ADON or LVN C notified the DON that they were unable to locate Resident #161's DNR and that the DON told them they had to call 911 and begin CPR because without the DNR in hand Resident #161 was considered a full code. She stated that facility staff began CPR just as EMS arrived and then they (EMS) took over. Hospice RN M stated she explained to the EMTs that the resident was pronounced dead at 3:40 pm and had been down since at least 3:17 pm and asked if they could just call their medical director and have them call a time of death, but they refused because there was no DNR available. She stated that the resident's MPOA told her that she had given the facility the DNR [DATE] and that she (MPOA) had personally handed it to LVN D. She stated that LVN C tore the building apart trying to find the DNR form but was not able to locate it. She stated the facility told the family and hospice that they never received the form. In an interview on [DATE] at 12:48 PM with DON she stated that DNRs were scanned into the charts and nurses, management (DON, ADON, Administrator, Social Worker, MDS) had access to the form once it was scanned in. She stated that CNAs had the code status listed on their Kardex (resident information sheet for non-nurses) but did not have access to the DNR form itself. She stated anyone with EHR access could see a resident's code status but not the DNR form. She stated Resident #161 had been a resident in the facility before and had always been a full code in the past, so she stated that the understanding that she was a DNR on her last admission was strange to her. DON confirmed that there were no hard copies of DNR forms kept in the facility. She stated that any prudent nurse would check for a DNR before taking any action in a code situation. She feels that the facility did everything they were supposed to do regarding Resident #161's admission. She stated she was admitted after business hours so the Social Worker who normally asked the advanced directive questions was not here to do it. She stated that the hospice administrator told her (DON) that there was a copy of the MPOA form so she believed maybe the family thought that was the DNR. DON stated there was no in-service done for the staff after the incident because she was not aware that the resident had been deceased for that amount of time before 911 was called and CPR was started and that there was so much confusion regarding her code status. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a phone interview on [DATE] at 4:29 PM Resident #161's MPOA stated she did not have a copy of the resident's DNR because the copy she gave the LVN E was the original document with a carbon copy attached. She stated that a hospice agent had taken a picture of the DNR with a cell phone for hospice records (surveyor was not able to verify this with any hospice employee). She stated that she gave the DNR to LVN E on [DATE] while he completed Resident #161's admission to the facility. She stated the hospice company had given Resident #161 the DNR paperwork to fill out. MPOA stated that after the resident completed the form, she (MPOA) and two other family members signed as witnesses on [DATE] and then gave the form to LVN E on [DATE]. MPOA stated that on [DATE] she and several family members were in the room when Resident #161 passed at approximately 3:20 pm. She stated she ran to get LVN C, who came to assess the resident, and that LVN C confirmed that Resident #161 had passed. She stated that LVN C then left the room to call hospice. MPOA stated that Hospice RN M arrived a short time later (she was not sure of the exact time) and pronounced time of death for the resident at 3:40 pm. MPOA stated that the family left the facility after Hospice RN M pronounced Resident #161 deceased . She stated she was called by Hospice RN M a while later to advise her that the facility staff could not locate the DNR and were calling 911 and starting compressions (MPOA was unable to give any exact times for phone calls). She stated that after the EMTs arrived and had taken over CPR, Hospice RN M had her (MPOA) on speaker phone telling the EMTs that she was the MPOA and to stop CPR, but they refused because they did not have the DNR and could not prove she was who she said she was over the phone. She stated she was told by Hospice RN M that the EMTs called their physician for orders to stop CPR and a new time of death was given. In an interview on [DATE] at 5:25 PM LVN F (6a-6p) Stated she has a cheat sheet that she worked off when doing admissions, but she stated that a lot of the admission tasks will queue to be done in the EHR system. She stated that the Social Worker was normally the person responsible for the Code Status Discussion but anyone who did an admission had access to that assessment and was able to complete it. She stated that she believed that the Code Status Discussion flagged in the UDAs (user-defined assessments) for nursing staff a few days after admission if it had not been completed. She also stated that if a resident was admitted with a DNR in hand she would not complete the Code Status Discussion. She stated that if she admitted a resident after hours or on a weekend that expressed interest in becoming a DNR she would bypass the Code Status Discussion and go straight to filling out the DNR form, or if a resident that could not communicate was declining, she would call the family and have the code status discussion with them. She stated she would never wait on the Social Worker to have the code status discussion. In an interview on [DATE] at 6:00 PM RN G (6p-6a) stated there was a list of assessments that had to be completed for an admission. She stated that management would let them know they were going to get an admission so she would have everything she needed to do ready; hospitals should give a report so she should know basic information about the resident before they arrived. RN G stated when a new resident arrived the first thing, she checked was code status because even a DNR outside the facility was considered a full code in the facility until they were assessed by the Social Worker. She stated that if a new resident came in with a DNR form in hand she would honor the DNR and notify the DON and document that she received the DNR even if the code status had not yet been set to reflect it. She stated she have the code status discussion with residents, but she has never done the actual assessment in PCC and was not aware it was there. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a follow-up interview on [DATE] at 8:50 AM LVN C stated that she received report from LVN E on [DATE] at 6:00 AM that Resident #161 had been admitted to the facility to die and was a DNR. She stated that she was working Monday through Thursday only during that time due to her school schedule and another nurse was working only weekends, so [DATE] was the first day she had been responsible for the care of Resident #161. She stated that when the family called her into the room, they told her that Resident #161 had stopped breathing. She stated she assessed the resident for a pulse and breath sounds and after finding none, she told the family that she would notify hospice then left the family to be with the resident. She stated that she called to notify hospice that the resident had expired. She stated that the family left almost immediately after Hospice RN M arrived and pronounced the time of death at 3:40 pm. She stated that she was uncertain who realized that the resident did not have a DNR on file and was listed as a full code. She stated that the ADON, who was working the opposite hall, called the DON and notified her that the Resident #161 did not have a DNR on file and was listed as a Full Code, but had been pronounced dead at 3:40 pm by Hospice RN M. At approximately 4:10 pm the ADON came to her nurse's station and notified her that the DON had said that because there was no DNR on file they had to start CPR and call 911. LVN C stated that in the nine hours she was responsible for Resident #161 the family never said anything to her specifically about the resident being a DNR. She did recall the family asking questions about how long it would take for the resident to pass and what to expect and requested that she call the hospice chaplain to come visit with them. She stated that in her opinion the family was aware the resident's death was imminent and their priority was making sure she was comfortable and not suffering in her last hours. She stated she was not aware that she could complete the Code Status Discussion Assessment with new admissions. She stated that she has initiated the DNR form with residents before but was not aware that the form would be honored before the physician had signed it. She stated that she does not have access to scan documents into the resident EHRs so even if she was given a DNR or other form by a resident/family on admission it would have to wait until management or medical records staff was available to upload the document. She stated that when she was looking for Resident #161's DNR form she was unable to find paper copies of any of her admission paperwork in the building. In a phone interview on [DATE] at 10:07 AM Medical Director stated that the facility does address code status on admission. She stated that if the resident was a full code, the facility was very quick to react to the situation. Medical Director stated that in a code situation the staff did compressions and ventilation until EMS arrived and took over resuscitation efforts. She stated that if the resident is a DNR the facility was to honor that and if the resident wished to become a DNR the Social Worker was to assist them in completing the paperwork. She stated that any licensed staff would be able to have the code status discussion with a resident or their representative and if there was an admission on a weekend or holiday the discussion still needed to happen, and it should never be put on hold until the Social Worker came back to work. Medical Director stated that she had not been made aware of the situation regarding Resident #161 and stated that the fact the resident had an MPOA would negate the need for a DNR. She stated that the DON should have instructed the facility nurses to contact the MPOA and get permission to not do CPR after staff realized the DNR was not in the facility rather than instructing them to call 911 and begin CPR. She stated that this was poor advise on the part of the DON. She stated that there was a clear lack of judgement on everyone's part. Review of blank, undated facility form titled Admission Checklist - Morning Clinical Meeting form revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review New Admissions - 'EHR' and other relevant sources - Grey shaded areas with asterisk should be completed within 24 hours, and other items on checklist should be completed within 3 days of admission. Gray shaded areas with asterisk: Vitals, Height, & Weight; Admission Assessment - Schedule Initiated & UDAs Complete; Admission Nurse Narrative Note Completed; Physician Orders Including Diet; Medication Review & Reconciliation; Photograph; Code Status/OOH DNR; Admission MDS Opened by Admission Nurse; Section GG Nursing Documentation Initiated; Physician Certification Initiated Review of undated facility policy titled DNR Policy revealed, in part: The resident has the right to make the decision about completion of the DNR. A DNR signed by the resident that has TWO valid witnesses to the signature and is dated is a valid legal document. Physician signature is only required for acknowledgement purposes and is not an approval for the DNR. The resident has the right to make the decision without the physician's permission and it has to be honored as long as it is executed properly with the resident's signature, date, and witnesses. A resident with a properly executed DNR should not be considered a FULL CODE while waiting for the physician to acknowledge the DNR. The following steps will be followed to reflect the resident's Do Not Resuscitate status accurately in 'EHR'. 1. Upon admission of a new resident, the charge nurse will determine the resident's code status. If the resident opts to complete an OOH-DNR, you will do the following: A. Review and complete an OOH-DNR with the resident/MPOA/Legal Guardian or next of kin and obtain witnesses or notary signatures on the form. This conversation is documented in the Code Status Discussion UDA. B. Request nursing change resident's code status to Do Not Resuscitate in 'EHR'. C. Scan OOH-DNR form and email to the resident's facility physician for signature. It is recommended to highlight all the places where the physician is to sign/date/license on the document. D. Upon receipt of the signed OOH-DNR, scan and upload to MISC. tab in 'EHR' under 'Advanced Directives'. 2. Follow up with the resident quarterly and upon change of condition to review/clarify code status, Advanced Directives, Medical Power of Attorney to ensure that what the resident has in place is still consistent with their wishes. Review of undated facility policy titled Full Code Status revealed: The following steps will be followed to reflect the resident's Full Code status accurately in 'EHR'. 1. Upon admission of a new resident, the admitting nurse will determine the resident's code status. If the resident chooses Full Code, the nurse enters a 'Full Code' order into 'EHR'. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. During 48-hour care plan meeting, social worker or designee will review code status with resident and/or resident representative This discussion is documented in the Code Status Discussion UDA. 3. Any Advanced Directives such as Medical Power of Attorney or other documents are uploaded to 'EHR' under the Miscellaneous tab under 'Advanced Directives. 4. Follow up with the resident quarterly and upon change of condition to review/clarify code status, Advanced Directives, Medical Power of Attorney to ensure that what the resident has in place is still consistent with what he/she wants. IJ was identified due to the above failures on [DATE] at 3:59 pm, and the IJ Template was provided to the Administrator. The Plan of Removal was accepted [DATE] at 3:05 pm and included: F578: The facility failed to have a system in place to ensure residents' Advanced Directives are accurately addressed and assessed at time of admission. Identify residents who could be affected. - All residents have the potential to be affected. - Facility census on [DATE] was 55. In-Service Conducted - All staff will be in-serviced on how to obtain the code status for all residents by utilizing the DNR code book found at each nurse's station. - DON, ADON, Regional Nurse Consultant will provide the training beginning [DATE] and continued until completed on [DATE] for current employees and all new hires. - Verbal understanding will be utilized for knowledge retention. Implementation of Changes - DNR and full code status audit was completed by Regional Nurse Consultant and DON on [DATE] for accuracy in 'EHR'. There were no issues identified on this audit, so no corrections were needed . - DON/ADON/Social Worker will audit once weekly for 3 months for 'EHR' accuracy. This audit was 100% of all current residents to include new admissions. - Code Status discussion will be conducted by social worker during business hours Monday through Friday and after 5 pm or weekends, holidays, charge nurses assigned a new admission will be completing code status discussion with residents or resident representative. - Weekend supervisor will verify completion of code status. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- Full code or DNR will be put in 'EHR at that time and or assisting with DNR paperwork. Administrator/DON/weekend RN supervisor will verify completion of the discussion daily and accurately documented in 'EHR' beginning [DATE]. - DON/ADON will review code status discussion after hours daily including holidays for new admissions beginning [DATE]. - All new admissions on weekends will be addressed in the morning meeting for accuracy of code status and confirm code status and resident rights, documented in 'EHR', DNR uploaded in 'EHR' and DNR binders at each nurse's station. - In-service will be conducted starting today regarding code status discussion and after-hours process. DNR binders will be at both nurses' stations. - DNR binders are to be easily accessible for new DNR requests and filled out by the charge nurse if requested. - DNR binders are the binders that will contain the completed Out of Hospital DNR for all residents with advanced directives. - Code status will be reviewed quarterly at the care plan conference. - Nurses will be made aware of code status changes by communicating via the 24-hour report which contains all new telephone orders, verbal shift change discussion daily on each shift, social worker may also communicate the change in a code status. Monitoring - DON/ADON will review code status discussions Monday through Friday and weekend supervisor will be monitoring for accuracy. - Any negative outcomes will be reported to the QAPI committee monthly for 3 months and if no concerns, consider it resolved. Involvement of Medical Director - The Medical Director was notified about the immediate jeopardy on [DATE]. The Survey Team conducted POR verification [DATE]. In interviews conducted on [DATE] from 12:04 pm to 4:30 pm, 8 nursing staff and the Director of Rehab confirmed they received in-services on the DNR books, CPR, the Code Status Discussion, and DNR/Code Status paperwork and were able to give the location of the DNR books and how to find a resident's code status in the EHR. Review of facility in-service dated [DATE] titled DNR Book, CPR, Code Status Discussion revealed: (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. Codes Status Discussion will be done on admit and after-hours (weekends) by charge nurses. Social Worker will do them M-F. 2. DNR books on both nurse's stations contain DNR (blank) to fill out upon request. 3. Code status is located under care profile and 2nd confirmation is Code Status book. 4. All nurses must have American Heart or Red Cross for CPR card. If you do not have these, get one ASAP or certification. Review of facility in-service dated [DATE] titled DNR Code Status/Paperwork revealed: 1. DNR CODE BOOK - where - nurse's station at both ends with all current residents; contains DNR paperwork to verify code status - secondary. EHR primary code status access Review of DNR/Code Status Books on [DATE] revealed that each book contained blank OOH-DNR forms in the front pocket. The first page in each book was a disclaimer stating A DNR should not be held as incomplete if there is not a physician's signature. A DNR is considered in effect once it is filled out and awaiting a physician's signature. Once filled out DNR should be sent to the physician for signature and telephone order written. Again, this DNR that has not yet been signed by the physician YET is still IN EFFECT. The books were then divided alphabetically and contained copies of the DNR forms for each resident in the facility who had a form on record. Each book contained the forms for all DNR residents in the facility, not just those residents at the nurse's station the resident was attached to. The back of the books contained several instructional versions of DNR forms that were highlighted with directions on who needed to sign in each area and who to call for questions as well as how to write telephone orders for a resident's code status. The Administrator was notified that the Immediate Jeopardy was removed on [DATE] at 5:41 pm, the facility remained out of compliance at a scope of isolated at a level of no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on interview and record review, the facility failed to ensure the resident had the right to be free from neglect for 1 of 17 (Resident #161) residents reviewed for neglect. The facility failed to ensure there was a system in place to assess code status adequately and accurately during the admission process after regular business hours, on weekends, and on holidays, resulting in Resident #161's code status not being assessed correctly during her admission to the facility on hospice services [DATE] at 8:00 pm. This failure also resulted in Resident #161's code status remaining listed as Full Code when she became unresponsive on [DATE]. These failures resulted in Hospice RN M pronouncing the resident deceased at 3:40 pm and LVN C calling 911 and initiating CPR on [DATE] at approximately 4:15 pm (approximately 63 minutes after LVN C was notified she had stopped breathing) due to being unable to locate Resident #161's DNR form. The facility failed to ensure that nursing staff provided Resident #161, who was listed as a Full Code, CPR, after the resident was reported to LVN C as not breathing, according to professional standards of practice. LVN C failed to verify Resident #161's code status before calling hospice which led to the resident being pronounced dead and CPR not being initiated for approximately 63 minutes after the resident was found to be unresponsive. An Immediate Jeopardy (IJ) was identified on [DATE] at 3:59 pm and the IJ Template was provided to the facility Administrator. While the Plan of Removal (POR) was accepted on [DATE] at 3:05 pm and the immediacy was removed on [DATE] at 5:41 pm, the facility remained out of compliance at a scope of isolated at a level of no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place the residents at risk of not having their wishes known, respected, and implemented in an emergency and could place residents who are a full code-status (all resuscitative measures to be taken to keep a person alive) at risk of death. The findings included: Review of Resident #161's Admission Record revealed she was an [AGE] year-old female originally admitted to the facility [DATE] with a most recent admitted [DATE]. She had admission diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), moderate malnutrition, breast cancer, chronic pain, and atrial fibrillation (abnormal heart rhythm). Her code status was listed as Full Code. Review of Resident #161's MDS list revealed that at the time of her [DATE] admission, no comprehensive MDS assessment had been initiated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #161's Hospice Clinical Chart revealed that during her intake interview and assessment on [DATE] at 3:52 pm, the resident was a full code but requested DNR paperwork (there was no DNR form located in the resident's EHR during record review) be given to her and her family to fill out. Review of Resident #161's Hospice admission orders dated [DATE] revealed no mention of code status. Review of Resident #161's Admission Assessment/Baseline Care Plan Summary, initiated [DATE] by LVN E and signed [DATE] by LVN C and DON, revealed in Section O Code Status that she was a DNR. Review of Resident #161's Physician's Progress Notes revealed no mention of code status in the admission note. Review of Resident #161's care plan dated [DATE] revealed Problem: I have chosen DO NOT RESUSCITATE status. Review of Resident #161's Order Listing Report revealed no order for code status. Review of facility's handwritten 24-hour report log for dates [DATE] and [DATE] revealed Resident #161 was reported as being a DNR. The 24-hour report log sheet dated [DATE] stated Resident #161 re-admit, COPD, moderate protein-calorie malnutrition, hospice. The facility was unable to provide the 24-hour report log for [DATE]. Review of Resident #161's Progress Notes revealed the following: Nurse's Note by LVN C on [DATE] at 3:12 pm Called to room by family. Resident without respirations or heartbeat. Family remains at bedside. Call placed to hospice requesting on call nurse be notified. Nurse's Note by LVN C on [DATE] at 3:18 pm Chaplain here to see resident and family. Nurse's Note by LVN C on [DATE] at 3:49 pm Hospice RN M with hospice here. Nurse's Note by LVN C on [DATE] at 3:59 pm Hospice nurse notified funeral home of need to pick resident up. There were no further notes found in Resident #161's chart. Review of Resident #161's Hospice Client Coordination Note Report revealed the following: Triage Note dated [DATE]: LVN C called triage nurse [DATE] at 3:17 pm to report Resident #161 had expired with family present. Hospice RN M was notified at 3:22 pm and was en route to the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Narrative Note dated [DATE] by Hospice RN M: Patient resting in bed with no breaths noted. HSN auscultated (listened with a stethoscope) for over one minute apical (over the heart). No pulse noted. TOD 1540 (3:40 pm). Funeral Home called 1600 (4:00 pm). CPR started at 1620 (4:20 PM) by paramedics due to facility not able to produce DNR in hand. MPOA called. She wants CPR stopped but per paramedic they cannot stop CPR over the phone with MPOA. Facility staff searching for DNR called maintenance to open the office to find the paper copy. Paramedics continue CPR until 1647 (4:47 pm). HSN filled out paperwork for mortician and facility. Body released to funeral home at 1705 (5:05 pm). Review of Resident #161's EMS Patient Care Record dated [DATE] revealed the following: Incident Narrative: Upon arrival the patient presented in the supine (on back) position in bed. NH staff were ventilating the patient with a BVM. NH staff initially informed EMS that patient stopped breathing at approximately 16:00 (4:00pm) today. EMS palpated (felt with fingers) the patient for a pulse, and none were noted. EMS moved the patient to the floor without incident using a patient carry. EMS began manual compressions and ventilating the patient. A NH employee entered the room and informed EMS that the patient has a DNR, but they are unable to locate it. EMS informed the employee that we must see a valid, physical copy of the DNR in order to cease resuscitative efforts. The NH employee never returned with a physical DNR. EMS attached multi pads (adhesive pads to detect heart rhythm) and the patient's rhythm was asystole (no detectable heartbeat) and remained asystole for the duration of the incident. IO access (technique in which the bone marrow cavity is used as a non-collapsible vascular entry point for delivering fluid or blood products) was gained, and EMS began administering LR (IV fluid). EMS inserted [NAME] (artificial airway used to help ventilate the patient) and attached the ETCO2 monitor and accuvent (attachment to monitor flow of air while ventilating patient). EMS proceeded to follow asystole protocol with pulse checks every 2 minutes and administering epinephrine every ,d+[DATE] minutes. EMS administered D10 (IV fluid). EMS obtained a 4-lead EKG. Approximately 15 minutes into the call a NH employee entered the room and informed EMS that the patient had stopped breathing at approximately 15:17 (3:17 pm) today. After approximately 25 minutes of CPR, EMS contacted medical control and informed physician on call of the details and interventions performed and the physician directed EMS to cease resuscitative efforts and called the time of death at 16:47 (4:47 pm) on [DATE]. EMS acquired a signature from the NH staff. EMS cleared the scene and returned to service. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a phone interview on [DATE] at 2:53 PM with the Hospice Administrator she stated that the hospice company never received a copy of Resident #161's DNR from the family as they were told that the family was going to be providing a copy to the nursing home to keep on file. She stated that the hospice company was told that the family had given a copy of the DNR to facility LVN D on Friday [DATE] when the resident was admitted to the facility and that LVN D either had or was going to enter it into the computer system. She stated that the resident had been living in an assisted living facility but was hospitalized and had a significant decline after being discharged from the hospital and the family opted for her to be placed on hospice services and be admitted to the nursing facility. She stated that when all the hospice paperwork was signed by the family, the family kept the DNR paperwork and assured the hospice employee that they would give the nursing home a copy. She stated that the hospice company offered the family a counseling session with their Social Worker to discuss the DNR paperwork and their options, but the family declined because there was already a DNR in place. The Hospice Administrator stated that on [DATE] a facility nurse called the hospice to notify the Hospice RN M that the resident had passed away. She stated that, according to the call log notes, LVN C notified the hospice company on [DATE] at 3:17 pm that Resident #161 had passed away and was requesting a hospice nurse be sent to the facility. She stated that according to Hospice RN M's notes and discussions she had after the incident with Hospice RN M, Hospice RN M arrived at the facility at approximately 3:35 pm and pronounced a time of death for Resident #161 at 3:40 PM. She stated that after Resident #161 had been pronounced deceased , LVN C tried to find the DNR form and when LVN C could not locate the DNR, instructed someone in the facility to call 911 and they (facility staff) began chest compressions. In a phone interview on [DATE] at 4:29 PM Resident #161's MPOA stated she did not have a copy of the resident's DNR because the copy she gave the LVN E was the original document with a carbon copy attached. She stated that a hospice agent had taken a picture of the DNR with a cell phone for hospice records (surveyor was not able to verify this with any hospice employee). She stated that she gave the DNR to LVN E on [DATE] while he completed Resident #161's admission to the facility. She stated the hospice company had given Resident #161 the DNR paperwork to fill out. MPOA stated that after the resident completed the form, she (MPOA) and two other family members signed as witnesses on [DATE] and then gave the form to LVN E on [DATE]. MPOA stated that on [DATE] she and several family members were in the room when Resident #161 passed at approximately 3:20 pm. She stated she ran to get LVN C, who came to assess the resident, and that LVN C confirmed that Resident #161 had passed. She stated that LVN C then left the room to call hospice. MPOA stated that Hospice RN M arrived a short time later (she was not sure of the exact time) and pronounced time of death for the resident at 3:40 pm. MPOA stated that the family left the facility after Hospice RN M pronounced Resident #161 deceased . She stated she was called by Hospice RN M a while later to advise her that the facility staff could not locate the DNR and were calling 911 and starting compressions (MPOA was unable to give any exact times for phone calls). She stated that after the EMTs arrived and had taken over CPR, Hospice RN M had her (MPOA) on speaker phone telling the EMTs that she was the MPOA and to stop CPR, but they refused because they did not have the DNR and could not prove she was who she said she was over the phone. She stated she was told by Hospice RN M that the EMTs called their physician for orders to stop CPR and a new time of death was given. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 3:30 PM LVN C stated that Resident #161's MPOA told her that she had given a copy of the DNR to LVN E on the night before the resident passed away ([DATE]). She stated that there were several family members in the room, including the MPOA, when the resident passed (she could not recall the exact time she was called to the room but stated she had put a note in the resident's chart documenting the time she was notified by the family that Resident #161 had stopped breathing) and after hospice pronounced a time of death the family left the facility. LVN C stated she called 911 at 4:11 PM on [DATE]. She stated she called 911 after about 30 minutes of searching the facility for a copy of Resident #161's DNR after the she had called hospice to notify them that the resident had expired, and the hospice nurse had already pronounced a time of death. She stated that after the hospice nurse pronounced the resident, she (LVN C) realized she had not verified the resident's code status and when she went to check she found there was no DNR on file for the resident. She stated that she should have verified the code status before calling hospice to pronounce. LVN C stated that when the paramedics arrived, the family had already left the facility, so she called the MPOA, who did not answer, so she called another family member to explain that because they did not have a copy of the DNR they had to try to resuscitate and were calling 911. She stated that Hospice RN M was able to get the MPOA on the phone while the paramedics were doing CPR and she (the MPOA) was telling them to stop, and they refused because there was no way to prove she was who she said she was and there was no DNR. LVN C stated that facility policy was if there was no DNR on file you called 911 and started CPR. LVN C stated the resident was on hospice for comfort measures but was listed as a full code was her understanding, but she had been told during shift report with LVN E that Resident #161 was a DNR. She stated that whoever received records for a new resident's admission would be responsible for making sure there was a DNR on file. In an interview on [DATE] at 10:30 AM with Social Worker, he stated that his role in the code status process was to have a Code Status Discussion with the resident or their representative within 48 hours of admission. He stated the discussion was a simple conversation about what the resident would like to have done if their heart stops while they are a resident, basically CPR or no CPR. He stated he did not get the chance to do the Code Status discussion with Resident #161 due to her admission being after business hours on [DATE] and her passing away on a holiday. He stated he had done a Code Status Discussion with her during her previous admission (,d+[DATE]), and she was a full code. He stated that whoever admitted the resident would have been responsible for getting the copy of the DNR from the family if there was one. He stated if he was the one who takes the DNR from the family he immediately scanned it and uploaded it into the resident's EHR. He stated that he did not have a hard copy DNR book, and he was pretty sure the nurses did not have hard copies of the residents' DNRs either. In an interview on [DATE] at 11:27 AM the Administrator confirmed that facility did not keep hard copies of DNRs on hand in the facility. He stated that all DNRs were kept in resident charts in the facility's EHR and code status was flagged for each resident and that the code status was accessible to all staff with EHR access. (continued on next page)

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	676031	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Nursing and Rehabilitation	4343 Oak Grove Blvd San Angelo, TX 76904

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 04:09 PM ADON stated she was working the floor on [DATE]. She stated the DON called her and asked her to go to the other side of the facility to help LVN C with Resident #161, so she grabbed the crash cart (rolling cart containing medication and equipment for emergency resuscitations) and went to the other side of the building and went to the resident's room. She stated that she (ADON) and LVN C had just started CPR as the EMTs arrived and took over. She was unable to give any times for the events of that day. ADON stated that when an admission was done, they (staff completing the admission) were supposed to get their own copies of all paperwork including advanced directives. She stated that Resident #161 was a hospice resident, and she feels like they should have provided the facility with the DNR. She stated that the Admission/Readmission Evaluation in the EHR can be initiated by one nurse and finished/signed by a different nurse depending on what time the resident is admitted because of shift change, then the RN signs off on it and there was no way to tell which nurse completed which section, only who initiated the assessment and who signed it. She stated that even if the admission evaluation and the care plan stated that the resident was a DNR, until the facility had the physical copy of the form the resident was considered a full code. In an interview on [DATE] at 04:50 PM LVN D stated he could not remember if he worked [DATE] through [DATE] without looking at a schedule. He stated he did not remember Resident #161 and denied that he was given a DNR for Resident #161 at any time. In a phone interview on [DATE] at 08:55 AM LVN E stated he did not remember Resident #161. He stated the facility had a high amount resident turnover and if a resident was not long-term it was difficult to remember all the residents. He stated that when he admitted a new resident, he would keep all the admission paperwork at the nurse's desk in a basket for medical records to pick up and scan into the chart. He stated that if he did receive Resident #161's DNR form with her admission paperwork it would have gone into the medical records basket with the other paperwork. He stated that each nurse's station had one of these baskets. He stated that each nurse's station had one of these baskets. LVN E stated all paperwork that the nurses needed scanned into charts went into that basket for medical records. He stated the paperwork in the basket was normally picked up the next day or if it was a weekend, it was picked up Monday morning. He stated that he did not have access to scan documents into resident charts and did not think the other nurses did either. In an interview on [DATE] at 11:31 AM Hospice RN M stated she received the call that Resident #161 had passed away at 3:17 pm on [DATE] and it took her a little while to get to the facility. She stated that when she arrived, she assessed the resident and spoke with the family, and she pronounced the resident's time of death as 3:40 pm. She stated that she explained to the family that she would notify the funeral home and make arrangements for the funeral home to contact the family to set up their next steps and that after the family spent a few minutes with the resident they left the facility. She stated that at some point (she was never told what time the call was placed), either ADON or LVN C notified the DON that they were unable to locate Resident #161's DNR and that the DON told them they had to call 911 and begin CPR because without the DNR in hand Resident #161 was considered a full code. She stated that facility staff began CPR just as EMS arrived and then they (EMS) took over. Hospice RN M stated she explained to the EMTs that the resident was pronounced dead at 3:40 pm and had been down since at least 3:17 pm and asked if they could just call their medical director and have them call a time of death, but they refused because there was no DNR available. She stated that the resident's MPOA told her that she had given the facility the DNR [DATE] and that she (MPOA) had personally handed it to LVN D. She stated that LVN C tore the building apart trying to find the DNR form but was not able to locate it. She stated the facility told the family and hospice that they never received the form. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 12:48 PM with DON she stated that LVN C should have checked Resident #161's code status before calling hospice because a resident can be on hospice without being a DNR. She stated that on [DATE] the ADON called her to notify her that Resident #161 had passed away and the Hospice RN M had pronounced her as deceased but after looking at the EHR, LVN C was unable to locate her DNR. She stated that she instructed the ADON at that time that without a DNR the resident was a full code and they needed to call 911 and start CPR. DON was unable to give a time for when the phone call took place. She stated that she was not informed of how long Resident #161 had been deceased when she was notified of the situation or she would have told the ADON to keep trying to contact the MPOA to verify the resident did not want CPR but because she did not have all the information, she followed facility protocol for a resident with full code status. She stated there was no in-service done for the staff after the incident because she was not aware that the resident had been deceased for such an extended amount of time before 911 was called and CPR was started and that there was so much confusion regarding her code status. In a phone interview on [DATE] at 4:29 PM Resident #161's MPOA stated that on [DATE] she and several family members were in the room when Resident #161 passed at approximately 3:20 pm. She stated she ran to get LVN C, who came to assess the resident, and that LVN C confirmed that Resident #161 had passed. She stated that LVN C then left the room to call hospice. MPOA stated that Hospice RN M arrived a short time later (she was not sure of the exact time) and pronounced time of death for the resident at 3:40 pm. MPOA stated that the family left the facility after Hospice RN M pronounced Resident #161 deceased . She stated she was called by Hospice RN M a while later to advise her that the facility staff could not locate the DNR and were calling 911 and starting compressions (MPOA was unable to give any exact times for phone calls). She stated that after the EMTs arrived and had taken over CPR, Hospice RN M had her (MPOA) on speaker phone telling the EMTs that she was the MPOA and to stop CPR, but they refused because they did not have the DNR and could not prove she was who she said she was over the phone. She stated she was told by Hospice RN M that the EMTs called their physician for orders to stop CPR and a new time of death was given. In an interview on [DATE] at 5:25 PM LVN F (6a-6p) Stated she has a cheat sheet that she worked off when doing admissions, but she stated that a lot of the admission tasks will queue to be done in the EHR system. She stated that the Social Worker was normally the person responsible for the Code Status Discussion but anyone who did an admission had access to that assessment and was able to complete it. She stated that she believed that the Code Status Discussion flagged in the UDAs (user-defined assessments) for nursing staff a few days after admission if it had not been completed. She also stated that if a resident was admitted with a DNR in hand she would not complete the Code Status Discussion. She stated that if she admitted a resident after hours or on a weekend that expressed interest in becoming a DNR she would bypass the Code Status Discussion and go straight to filling out the DNR form, or if a resident that could not communicate was declining, she would call the family and have the code status discussion with them. She stated she would never wait on the Social Worker to have the code status discussion. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 6:00 PM RN G (6p-6a) stated there was a list of assessments that had to be completed for an admission. She stated that management would let them know they were going to get an admission so she would have everything she needed to do ready; hospitals should give a report so she should know basic information about the resident before they arrived. RN G stated when a new resident arrived the first thing, she checked was code status because even a DNR outside the facility was considered a full code in the facility until they were assessed by the Social Worker. She stated that if a new resident came in with a DNR form in hand she would honor the DNR and notify the DON and document that she received the DNR even if the code status had not yet been set to reflect it. She stated she have the code status discussion with residents, but she has never done the actual assessment in PCC and was not aware it was there. In a follow-up interview on [DATE] at 8:50 AM LVN C stated that she received report from LVN E on [DATE] at 6:00 AM that Resident #161 had been admitted to the facility to die and was a DNR. She stated that she was working Monday through Thursday only during that time due to her school schedule and another nurse was working only weekends, so [DATE] was the first day she had been responsible for the care of Resident #161. She stated that when the family called her into the room, they told her that Resident #161 had stopped breathing. She stated she assessed the resident for a pulse and breath sounds and after finding none, she told the family that she would notify hospice then left the family to be with the resident. She stated that she called to notify hospice that the resident had expired. She stated that the family left almost immediately after Hospice RN M arrived and pronounced the time of death at 3:40 pm. She stated that she was uncertain who realized that the resident did not have a DNR on file and was listed as a full code. She stated that the ADON, who was working the opposite hall, called the DON and notified her that the Resident #161 did not have a DNR on file and was listed as a Full Code, but had been pronounced dead at 3:40 pm by Hospice RN M. At approximately 4:10 pm the ADON came to her nurse's station and notified her that the DON had said that because there was no DNR on file and Resident #161's code status was listed as Full Code, they had to start CPR and call 911. LVN C stated that at approximately 4:15 pm they began CPR with the ADON doing chest compressions and her (LVN C) ventilating Resident #161 with a bag valve mask until EMS arrived and took over. She acknowledged that with the time stamp from her progress note documenting the time the resident's family notified her that Resident #161 had stopped breathing, no less than 63 minutes had passed before CPR was initiated. In a phone interview on [DATE] at 10:07 AM Medical Director stated that the facility does address code status on admission. She stated that if the resident was a full code, the facility was very quick to react to the situation. Medical Director stated that in a code situation the staff did compressions and ventilation until EMS arrived and took over resuscitation efforts. She stated that if the resident is a DNR the facility was to honor that and if the resident wished to become a DNR the Social Worker was to assist them in completing the paperwork. She stated that any licensed staff would be able to have the code status discussion with a resident or their representative and if there was an admission on a weekend or holiday the discussion still needed to happen, and it should never be put on hold until the Social Worker came back to work. Medical Director stated that she had not been made aware of the situation regarding Resident #161 and stated that the fact the resident had an MPOA would negate the need for a DNR. She stated that the DON should have instructed the facility nurses to contact the MPOA and get permission to not do CPR after staff realized the DNR was not in the facility rather than instructing them to call 911 and begin CPR. She stated that this was poor advise on the part of the DON. She stated that there was a clear lack of judgement on everyone's part. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 1:15 PM Regional Director of Clinical Services stated the facility did not have a CPR policy. She stated the staff that were CPR certified rely on their training to know when to perform CPR. She stated she was the instructor for staff at the facility and they know when to do CPR. Review of blank, undated facility form titled Admission Checklist - Morning Clinical Meeting form revealed: Review New Admissions - 'EHR' and other relevant sources - Grey shaded areas with asterisk should be completed within 24 hours, and other items on checklist should be completed within 3 days of admission. Gray shaded areas with asterisk: Vitals, Height, & Weight; Admission Assessment - Schedule Initiated & UDAs Complete; Admission Nurse Narrative Note Completed; Physician Orders Including Diet; Medication Review & Reconciliation; Photograph; Code Status/OOH DNR; Admission MDS Opened by Admission Nurse; Section GG Nursing Documentation Initiated; Physician Certification Initiated Review of facility policy titled Abuse, Negelct, Exploitation and Misappropriation Prevention Program revised [DATE], revealed, in part: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Develop and implement policies and protocols to prevent and identify: neglect of residents. Review of undated facility policy titled DNR Policy revealed, in part: The resident has the right to make the decision about completion of the DNR. A DNR signed by the resident that has TWO valid witnesses to the signature and is dated is a valid legal document. Physician signature is only required for acknowledgement purposes and is not an approval for the DNR. The resident has the right to make the decision without the physician's permission and it has to be honored as long as it is executed properly with the resident's signature, date, and witnesses. A resident with a properly executed DNR should not be considered a FULL CODE while waiting for the physician to acknowledge the DNR. The following steps will be followed to reflect the resident's Do Not Resuscitate status accurately in 'EHR'. 1. Upon admission of a new resident, the charge nurse will determine the resident's code status. If the resident opts to complete an OOH-DNR, you will do the following: A. Review and complete an OOH-DNR with the resident/MPOA/Legal Guardian or next of kin and obtain witnesses or notary signatures on the form. This conversation is documented in the Code Status Discussion UDA. B. Request nursing change resident's code status to Do Not Resuscitate in 'EHR'. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	C. Scan OOH-DNR form and email to the resident's facility physician for signature. It is recommended to highlight all the places where the physician is to sign/date/license on the document. D. Upon receipt of the signed OOH-DNR, scan and upload to MISC. tab in 'EHR' under 'Advanced Directives'. 2. Follow up with the resident quarterly and upon change of condition to review/clarify code status, Advanced Directives, Medical Power of Attorney to ensure that what the resident has in place is still consistent with their wishes. Review of undated facility policy titled Full Code Status revealed: The following steps will be followed to reflect the resident's Full Code status accurately in 'EHR'. 1. Upon admission of a new resident, the admitting nurse will determine the resident's code status. If the resident chooses Full Code, the nurse enters a 'Full Code' order into 'EHR'. 2. During 48-hour care plan meeting, social worker or designee will review code status with resident and/or RP. This discussion is documented in the Code Status Discussion UDA. 3. Any Advanced Directives such as Medical Power of Attorney or other documents are uploaded to 'EHR' under the Miscellaneous tab under 'Advanced Directives. 4. Follow up with the resident quarterly and upon change of condition to review/clarify code status, Advanced Directives, Medical Power of Attorney to ensure that what the resident has in place is still consistent with what he/she wants. An IJ was identified due to the above failures on [DATE] at 3:59 pm, and the IJ Template was provided to the Administrator. The Plan of Removal was accepted [DATE] at 3:05 pm and included: F600: - Facility failed to ensure a resident was free from neglect by failing to follow the resident's advanced directive. - CPR was not initiated for approximately 63 minutes after staff was notified by family that Resident #161 had stopped breathing. - Resident #16[TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on interview and record review, the facility failed to implement written policies that prohibit abuse and neglect for 1 of 17 (Resident #161) residents reviewed for neglect. The facility failed to ensure there was a system in place to assess code status adequately and accurately during the admission process after regular business hours, on weekends, and on holidays, resulting in Resident #161's code status not being assessed correctly during her admission to the facility on hospice services [DATE] at 8:00 pm. This failure also resulted in Resident #161's code status remaining listed as Full Code when she became unresponsive on [DATE]. These failures resulted in Hospice RN M pronouncing the resident deceased at 3:40 pm and LVN C calling 911 and initiating CPR on [DATE] at approximately 4:15 pm (approximately 63 minutes after LVN C was notified she had stopped breathing) due to being unable to locate Resident #161's DNR form. The facility failed to ensure that nursing staff provided Resident #161, who was listed as a Full Code, CPR, after the resident was reported to LVN C as not breathing, according to professional standards of practice. LVN C failed to verify Resident #161's code status before calling hospice which led to the resident being pronounced dead and CPR not being initiated for approximately 63 minutes after the resident was found to be unresponsive. An Immediate Jeopardy (IJ) was identified on [DATE] at 3:59 pm and the IJ Template was provided to the facility Administrator. While the Plan of Removal (POR) was accepted on [DATE] at 3:05 pm and the immediacy was removed on [DATE] at 5:41 pm, the facility remained out of compliance at a scope of isolated at a level of no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place the residents at risk of not having their wishes known, respected, and implemented in an emergency and could place residents who are a full code-status (all resuscitative measures to be taken to keep a person alive) at risk of death. The findings included: Review of facility policy titled Abuse, Negelct, Exploitation and Misappropriation Prevention Program revised [DATE], revealed, in part: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Develop and implement policies and protocols to prevent and identify: neglect of residents. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #161's Admission Record revealed she was an [AGE] year-old female originally admitted to the facility [DATE] with a most recent admitted [DATE]. She had admission diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), moderate malnutrition, breast cancer, chronic pain, and atrial fibrillation (abnormal heart rhythm). Her code status was listed as Full Code. Review of Resident #161's MDS list revealed that at the time of her [DATE] admission, no comprehensive MDS assessment had been initiated. Review of Resident #161's Hospice Clinical Chart revealed that during her intake interview and assessment on [DATE] at 3:52 pm, the resident was a full code but requested DNR paperwork (there was no DNR form located in the resident's EHR during record review) be given to her and her family to fill out. Review of Resident #161's Hospice admission orders dated [DATE] revealed no mention of code status. Review of Resident #161's Admission Assessment/Baseline Care Plan Summary, initiated [DATE] by LVN E and signed [DATE] by LVN C and DON, revealed in Section O Code Status that she was a DNR. Review of Resident #161's Physician's Progress Notes revealed no mention of code status in the admission note. Review of Resident #161's care plan dated [DATE] revealed Problem: I have chosen DO NOT RESUSCITATE status. Review of Resident #161's Order Listing Report revealed no order for code status. Review of facility's handwritten 24-hour report log for dates [DATE] and [DATE] revealed Resident #161 was reported as being a DNR. The 24-hour report log sheet dated [DATE] stated Resident #161 re-admit, COPD, moderate protein-calorie malnutrition, hospice. The facility was unable to provide the 24-hour report log for [DATE]. Review of Resident #161's Progress Notes revealed the following: Nurse's Note by LVN C on [DATE] at 3:12 pm Called to room by family. Resident without respirations or heartbeat. Family remains at bedside. Call placed to hospice requesting on call nurse be notified. Nurse's Note by LVN C on [DATE] at 3:18 pm Chaplain here to see resident and family. Nurse's Note by LVN C on [DATE] at 3:49 pm Hospice RN M with hospice here. Nurse's Note by LVN C on [DATE] at 3:59 pm Hospice nurse notified funeral home of need to pick resident up. There were no further notes found in Resident #161's chart. Review of Resident #161's Hospice Client Coordination Note Report revealed the following: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Triage Note dated [DATE]: LVN C called triage nurse [DATE] at 3:17 pm to report Resident #161 had expired with family present. Hospice RN M was notified at 3:22 pm and was en route to the facility. Narrative Note dated [DATE] by Hospice RN M: Patient resting in bed with no breaths noted. HSN auscultated (listened with a stethoscope) for over one minute apical (over the heart). No pulse noted. TOD 1540 (3:40 pm). Funeral Home called 1600 (4:00 pm). CPR started at 1620 (4:20 PM) by paramedics due to facility not able to produce DNR in hand. MPOA called. She wants CPR stopped but per paramedic they cannot stop CPR over the phone with MPOA. Facility staff searching for DNR called maintenance to open the office to find the paper copy. Paramedics continue CPR until 1647 (4:47 pm). HSN filled out paperwork for mortician and facility. Body released to funeral home at 1705 (5:05 pm). Review of Resident #161's EMS Patient Care Record dated [DATE] revealed the following: Incident Narrative: Upon arrival the patient presented in the supine (on back) position in bed. NH staff were ventilating the patient with a BVM. NH staff initially informed EMS that patient stopped breathing at approximately 16:00 (4:00pm) today. EMS palpated (felt with fingers) the patient for a pulse, and none were noted. EMS moved the patient to the floor without incident using a patient carry. EMS began manual compressions and ventilating the patient. A NH employee entered the room and informed EMS that the patient has a DNR, but they are unable to locate it. EMS informed the employee that we must see a valid, physical copy of the DNR in order to cease resuscitative efforts. The NH employee never returned with a physical DNR. EMS attached multi pads (adhesive pads to detect heart rhythm) and the patient's rhythm was asystole (no detectable heartbeat) and remained asystole for the duration of the incident. IO access (technique in which the bone marrow cavity is used as a non-collapsible vascular entry point for delivering fluid or blood products) was gained, and EMS began administering LR (IV fluid). EMS inserted [NAME] (artificial airway used to help ventilate the patient) and attached the ETCO2 monitor and accuvent (attachment to monitor flow of air while ventilating patient). EMS proceeded to follow asystole protocol with pulse checks every 2 minutes and administering epinephrine every ,d+[DATE] minutes. EMS administered D10 (IV fluid). EMS obtained a 4-lead EKG. Approximately 15 minutes into the call a NH employee entered the room and informed EMS that the patient had stopped breathing at approximately 15:17 (3:17 pm) today. After approximately 25 minutes of CPR, EMS contacted medical control and informed physician on call of the details and interventions performed and the physician directed EMS to cease resuscitative efforts and called the time of death at 16:47 (4:47 pm) on [DATE]. EMS acquired a signature from the NH staff. EMS cleared the scene and returned to service. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a phone interview on [DATE] at 2:53 PM with the Hospice Administrator she stated that the hospice company never received a copy of Resident #161's DNR from the family as they were told that the family was going to be providing a copy to the nursing home to keep on file. She stated that the hospice company was told that the family had given a copy of the DNR to facility LVN D on Friday [DATE] when the resident was admitted to the facility and that LVN D either had or was going to enter it into the computer system. She stated that the resident had been living in an assisted living facility but was hospitalized and had a significant decline after being discharged from the hospital and the family opted for her to be placed on hospice services and be admitted to the nursing facility. She stated that when all the hospice paperwork was signed by the family, the family kept the DNR paperwork and assured the hospice employee that they would give the nursing home a copy. She stated that the hospice company offered the family a counseling session with their Social Worker to discuss the DNR paperwork and their options, but the family declined because there was already a DNR in place. The Hospice Administrator stated that on [DATE] a facility nurse called the hospice to notify the Hospice RN M that the resident had passed away. She stated that, according to the call log notes, LVN C notified the hospice company on [DATE] at 3:17 pm that Resident #161 had passed away and was requesting a hospice nurse be sent to the facility. She stated that according to Hospice RN M's notes and discussions she had after the incident with Hospice RN M, Hospice RN M arrived at the facility at approximately 3:35 pm and pronounced a time of death for Resident #161 at 3:40 PM. She stated that after Resident #161 had been pronounced deceased , LVN C tried to find the DNR form and when LVN C could not locate the DNR, instructed someone in the facility to call 911 and they (facility staff) began chest compressions. In a phone interview on [DATE] at 4:29 PM Resident #161's MPOA stated she did not have a copy of the resident's DNR because the copy she gave the LVN E was the original document with a carbon copy attached. She stated that a hospice agent had taken a picture of the DNR with a cell phone for hospice records (surveyor was not able to verify this with any hospice employee). She stated that she gave the DNR to LVN E on [DATE] while he completed Resident #161's admission to the facility. She stated the hospice company had given Resident #161 the DNR paperwork to fill out. MPOA stated that after the resident completed the form, she (MPOA) and two other family members signed as witnesses on [DATE] and then gave the form to LVN E on [DATE]. MPOA stated that on [DATE] she and several family members were in the room when Resident #161 passed at approximately 3:20 pm. She stated she ran to get LVN C, who came to assess the resident, and that LVN C confirmed that Resident #161 had passed. She stated that LVN C then left the room to call hospice. MPOA stated that Hospice RN M arrived a short time later (she was not sure of the exact time) and pronounced time of death for the resident at 3:40 pm. MPOA stated that the family left the facility after Hospice RN M pronounced Resident #161 deceased . She stated she was called by Hospice RN M a while later to advise her that the facility staff could not locate the DNR and were calling 911 and starting compressions (MPOA was unable to give any exact times for phone calls). She stated that after the EMTs arrived and had taken over CPR, Hospice RN M had her (MPOA) on speaker phone telling the EMTs that she was the MPOA and to stop CPR, but they refused because they did not have the DNR and could not prove she was who she said she was over the phone. She stated she was told by Hospice RN M that the EMTs called their physician for orders to stop CPR and a new time of death was given. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 3:30 PM LVN C stated that Resident #161's MPOA told her that she had given a copy of the DNR to LVN E on the night before the resident passed away ([DATE]). She stated that there were several family members in the room, including the MPOA, when the resident passed (she could not recall the exact time she was called to the room but stated she had put a note in the resident's chart documenting the time she was notified by the family that Resident #161 had stopped breathing) and after hospice pronounced a time of death the family left the facility. LVN C stated she called 911 at 4:11 PM on [DATE]. She stated she called 911 after about 30 minutes of searching the facility for a copy of Resident #161's DNR after the she had called hospice to notify them that the resident had expired, and the hospice nurse had already pronounced a time of death. She stated that after the hospice nurse pronounced the resident, she (LVN C) realized she had not verified the resident's code status and when she went to check she found there was no DNR on file for the resident. She stated that she should have verified the code status before calling hospice to pronounce. LVN C stated that when the paramedics arrived, the family had already left the facility, so she called the MPOA, who did not answer, so she called another family member to explain that because they did not have a copy of the DNR they had to try to resuscitate and were calling 911. She stated that Hospice RN M was able to get the MPOA on the phone while the paramedics were doing CPR and she (the MPOA) was telling them to stop, and they refused because there was no way to prove she was who she said she was and there was no DNR. LVN C stated that facility policy was if there was no DNR on file you called 911 and started CPR. LVN C stated the resident was on hospice for comfort measures but was listed as a full code was her understanding, but she had been told during shift report with LVN E that Resident #161 was a DNR. She stated that whoever received records for a new resident's admission would be responsible for making sure there was a DNR on file. In an interview on [DATE] at 10:30 AM with Social Worker, he stated that his role in the code status process was to have a Code Status Discussion with the resident or their representative within 48 hours of admission. He stated the discussion was a simple conversation about what the resident would like to have done if their heart stops while they are a resident, basically CPR or no CPR. He stated he did not get the chance to do the Code Status discussion with Resident #161 due to her admission being after business hours on [DATE] and her passing away on a holiday. He stated he had done a Code Status Discussion with her during her previous admission (,d+[DATE]), and she was a full code. He stated that whoever admitted the resident would have been responsible for getting the copy of the DNR from the family if there was one. He stated if he was the one who takes the DNR from the family he immediately scanned it and uploaded it into the resident's EHR. He stated that he did not have a hard copy DNR book, and he was pretty sure the nurses did not have hard copies of the residents' DNRs either. In an interview on [DATE] at 11:27 AM the Administrator confirmed that facility did not keep hard copies of DNRs on hand in the facility. He stated that all DNRs were kept in resident charts in the facility's EHR and code status was flagged for each resident and that the code status was accessible to all staff with EHR access. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 04:09 PM ADON stated she was working the floor on [DATE]. She stated the DON called her and asked her to go to the other side of the facility to help LVN C with Resident #161, so she grabbed the crash cart (rolling cart containing medication and equipment for emergency resuscitations) and went to the other side of the building and went to the resident's room. She stated that she (ADON) and LVN C had just started CPR as the EMTs arrived and took over. She was unable to give any times for the events of that day. ADON stated that when an admission was done, they (staff completing the admission) were supposed to get their own copies of all paperwork including advanced directives. She stated that Resident #161 was a hospice resident, and she feels like they should have provided the facility with the DNR. She stated that the Admission/Readmission Evaluation in the EHR can be initiated by one nurse and finished/signed by a different nurse depending on what time the resident is admitted because of shift change, then the RN signs off on it and there was no way to tell which nurse completed which section, only who initiated the assessment and who signed it. She stated that even if the admission evaluation and the care plan stated that the resident was a DNR, until the facility had the physical copy of the form the resident was considered a full code. In an interview on [DATE] at 04:50 PM LVN D stated he could not remember if he worked [DATE] through [DATE] without looking at a schedule. He stated he did not remember Resident #161 and denied that he was given a DNR for Resident #161 at any time. In a phone interview on [DATE] at 08:55 AM LVN E stated he did not remember Resident #161. He stated the facility had a high amount resident turnover and if a resident was not long-term it was difficult to remember all the residents. He stated that when he admitted a new resident, he would keep all the admission paperwork at the nurse's desk in a basket for medical records to pick up and scan into the chart. He stated that if he did receive Resident #161's DNR form with her admission paperwork it would have gone into the medical records basket with the other paperwork. He stated that each nurse's station had one of these baskets. He stated that each nurse's station had one of these baskets. LVN E stated all paperwork that the nurses needed scanned into charts went into that basket for medical records. He stated the paperwork in the basket was normally picked up the next day or if it was a weekend, it was picked up Monday morning. He stated that he did not have access to scan documents into resident charts and did not think the other nurses did either. In an interview on [DATE] at 11:31 AM Hospice RN M stated she received the call that Resident #161 had passed away at 3:17 pm on [DATE] and it took her a little while to get to the facility. She stated that when she arrived, she assessed the resident and spoke with the family, and she pronounced the resident's time of death as 3:40 pm. She stated that she explained to the family that she would notify the funeral home and make arrangements for the funeral home to contact the family to set up their next steps and that after the family spent a few minutes with the resident they left the facility. She stated that at some point (she was never told what time the call was placed), either ADON or LVN C notified the DON that they were unable to locate Resident #161's DNR and that the DON told them they had to call 911 and begin CPR because without the DNR in hand Resident #161 was considered a full code. She stated that facility staff began CPR just as EMS arrived and then they (EMS) took over. Hospice RN M stated she explained to the EMTs that the resident was pronounced dead at 3:40 pm and had been down since at least 3:17 pm and asked if they could just call their medical director and have them call a time of death, but they refused because there was no DNR available. She stated that the resident's MPOA told her that she had given the facility the DNR [DATE] and that she (MPOA) had personally handed it to LVN D. She stated that LVN C tore the building apart trying to find the DNR form but was not able to locate it. She stated the facility told the family and hospice that they never received the form. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 12:48 PM with DON she stated that LVN C should have checked Resident #161's code status before calling hospice because a resident can be on hospice without being a DNR. She stated that on [DATE] the ADON called her to notify her that Resident #161 had passed away and the Hospice RN M had pronounced her as deceased but after looking at the EHR, LVN C was unable to locate her DNR. She stated that she instructed the ADON at that time that without a DNR the resident was a full code and they needed to call 911 and start CPR. DON was unable to give a time for when the phone call took place. She stated that she was not informed of how long Resident #161 had been deceased when she was notified of the situation or she would have told the ADON to keep trying to contact the MPOA to verify the resident did not want CPR but because she did not have all the information, she followed facility protocol for a resident with full code status. She stated there was no in-service done for the staff after the incident because she was not aware that the resident had been deceased for such an extended amount of time before 911 was called and CPR was started and that there was so much confusion regarding her code status. In a phone interview on [DATE] at 4:29 PM Resident #161's MPOA stated that on [DATE] she and several family members were in the room when Resident #161 passed at approximately 3:20 pm. She stated she ran to get LVN C, who came to assess the resident, and that LVN C confirmed that Resident #161 had passed. She stated that LVN C then left the room to call hospice. MPOA stated that Hospice RN M arrived a short time later (she was not sure of the exact time) and pronounced time of death for the resident at 3:40 pm. MPOA stated that the family left the facility after Hospice RN M pronounced Resident #161 deceased . She stated she was called by Hospice RN M a while later to advise her that the facility staff could not locate the DNR and were calling 911 and starting compressions (MPOA was unable to give any exact times for phone calls). She stated that after the EMTs arrived and had taken over CPR, Hospice RN M had her (MPOA) on speaker phone telling the EMTs that she was the MPOA and to stop CPR, but they refused because they did not have the DNR and could not prove she was who she said she was over the phone. She stated she was told by Hospice RN M that the EMTs called their physician for orders to stop CPR and a new time of death was given. In an interview on [DATE] at 5:25 PM LVN F (6a-6p) Stated she has a cheat sheet that she worked off when doing admissions, but she stated that a lot of the admission tasks will queue to be done in the EHR system. She stated that the Social Worker was normally the person responsible for the Code Status Discussion but anyone who did an admission had access to that assessment and was able to complete it. She stated that she believed that the Code Status Discussion flagged in the UDAs (user-defined assessments) for nursing staff a few days after admission if it had not been completed. She also stated that if a resident was admitted with a DNR in hand she would not complete the Code Status Discussion. She stated that if she admitted a resident after hours or on a weekend that expressed interest in becoming a DNR she would bypass the Code Status Discussion and go straight to filling out the DNR form, or if a resident that could not communicate was declining, she would call the family and have the code status discussion with them. She stated she would never wait on the Social Worker to have the code status discussion. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 6:00 PM RN G (6p-6a) stated there was a list of assessments that had to be completed for an admission. She stated that management would let them know they were going to get an admission so she would have everything she needed to do ready; hospitals should give a report so she should know basic information about the resident before they arrived. RN G stated when a new resident arrived the first thing, she checked was code status because even a DNR outside the facility was considered a full code in the facility until they were assessed by the Social Worker. She stated that if a new resident came in with a DNR form in hand she would honor the DNR and notify the DON and document that she received the DNR even if the code status had not yet been set to reflect it. She stated she have the code status discussion with residents, but she has never done the actual assessment in PCC and was not aware it was there. In a follow-up interview on [DATE] at 8:50 AM LVN C stated that she received report from LVN E on [DATE] at 6:00 AM that Resident #161 had been admitted to the facility to die and was a DNR. She stated that she was working Monday through Thursday only during that time due to her school schedule and another nurse was working only weekends, so [DATE] was the first day she had been responsible for the care of Resident #161. She stated that when the family called her into the room, they told her that Resident #161 had stopped breathing. She stated she assessed the resident for a pulse and breath sounds and after finding none, she told the family that she would notify hospice then left the family to be with the resident. She stated that she called to notify hospice that the resident had expired. She stated that the family left almost immediately after Hospice RN M arrived and pronounced the time of death at 3:40 pm. She stated that she was uncertain who realized that the resident did not have a DNR on file and was listed as a full code. She stated that the ADON, who was working the opposite hall, called the DON and notified her that the Resident #161 did not have a DNR on file and was listed as a Full Code, but had been pronounced dead at 3:40 pm by Hospice RN M. At approximately 4:10 pm the ADON came to her nurse's station and notified her that the DON had said that because there was no DNR on file and Resident #161's code status was listed as Full Code, they had to start CPR and call 911. LVN C stated that at approximately 4:15 pm they began CPR with the ADON doing chest compressions and her (LVN C) ventilating Resident #161 with a bag valve mask until EMS arrived and took over. She acknowledged that with the time stamp from her progress note documenting the time the resident's family notified her that Resident #161 had stopped breathing, no less than 63 minutes had passed before CPR was initiated. In a phone interview on [DATE] at 10:07 AM Medical Director stated that the facility does address code status on admission. She stated that if the resident was a full code, the facility was very quick to react to the situation. Medical Director stated that in a code situation the staff did compressions and ventilation until EMS arrived and took over resuscitation efforts. She stated that if the resident is a DNR the facility was to honor that and if the resident wished to become a DNR the Social Worker was to assist them in completing the paperwork. She stated that any licensed staff would be able to have the code status discussion with a resident or their representative and if there was an admission on a weekend or holiday the discussion still needed to happen, and it should never be put on hold until the Social Worker came back to work. Medical Director stated that she had not been made aware of the situation regarding Resident #161 and stated that the fact the resident had an MPOA would negate the need for a DNR. She stated that the DON should have instructed the facility nurses to contact the MPOA and get permission to not do CPR after staff realized the DNR was not in the facility rather than instructing them to call 911 and begin CPR. She stated that this was poor advise on the part of the DON. She stated that there was a clear lack of judgement on everyone's part. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 1:15 PM Regional Director of Clinical Services stated the facility did not have a CPR policy. She stated the staff that were CPR certified rely on their training to know when to perform CPR. She stated she was the instructor for staff at the facility and they know when to do CPR. Review of blank, undated facility form titled Admission Checklist - Morning Clinical Meeting form revealed: Review New Admissions - 'EHR' and other relevant sources - Grey shaded areas with asterisk should be completed within 24 hours, and other items on checklist should be completed within 3 days of admission. Gray shaded areas with asterisk: Vitals, Height, & Weight; Admission Assessment - Schedule Initiated & UDAs Complete; Admission Nurse Narrative Note Completed; Physician Orders Including Diet; Medication Review & Reconciliation; Photograph; Code Status/OOH DNR; Admission MDS Opened by Admission Nurse; Section GG Nursing Documentation Initiated; Physician Certification Initiated Review of undated facility policy titled DNR Policy revealed, in part: The resident has the right to make the decision about completion of the DNR. A DNR signed by the resident that has TWO valid witnesses to the signature and is dated is a valid legal document. Physician signature is only required for acknowledgement purposes and is not an approval for the DNR. The resident has the right to make the decision without the physician's permission and it has to be honored as long as it is executed properly with the resident's signature, date, and witnesses. A resident with a properly executed DNR should not be considered a FULL CODE while waiting for the physician to acknowledge the DNR. The following steps will be followed to reflect the resident's Do Not Resuscitate status accurately in 'EHR'. 1. Upon admission of a new resident, the charge nurse will determine the resident's code status. If the resident opts to complete an OOH-DNR, you will do the following: A. Review and complete an OOH-DNR with the resident/MPOA/Legal Guardian or next of kin and obtain witnesses or notary signatures on the form. This conversation is documented in the Code Status Discussion UDA. B. Request nursing change resident's code status to Do Not Resuscitate in 'EHR'. C. Scan OOH-DNR form and email to the resident's facility physician for signature. It is recommended to highlight all the places where the physician is to sign/date/license on the document. D. Upon receipt of the signed OOH-DNR, scan and upload to MISC. tab in 'EHR' under 'Advanced Directives'. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. Follow up with the resident quarterly and upon change of condition to review/clarify code status, Advanced Directives, Medical Power of Attorney to ensure that what the resident has in place is still consistent with their wishes. Review of undated facility policy titled Full Code Status revealed: The following steps will be followed to reflect the resident's Full Code status accurately in 'EHR'. 1. Upon admission of a new resident, the admitting nurse will determine the resident's code status. If the resident chooses Full Code, the nurse enters a 'Full Code' order into 'EHR'. 2. During 48-hour care plan meeting, social worker or designee will review code status with resident and/or RP. This discussion is documented in the Code Status Discussion UDA. 3. Any Advanced Directives such as Medical Power of Attorney or other documents are uploaded to 'EHR' under the Miscellaneous tab under 'Advanced Directives. 4. Follow up with the resident quarterly and upon change of condition to review/clarify code status, Advanced Directives, Medical Power of Attorney to ensure that what the resident has in place is still consistent with what he/she wants. An IJ was identified due to the above failures on [DATE] at 3:59 pm, and the IJ Template was provided to the Administrator. The Plan of Removal was accepted [DATE] at 3:05 pm and included: F600: - Facility failed to ensure a resident was free from neglect by failing to follow the resident's advanced directive. - CPR was not initiated for approximately 63 minutes after staff was notified by family that Resident #161 had stopped breathing. - Resident #161 did not

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 45411 Based on interview and record review the facility personnel failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders follow physician orders and the resident's advance directives for 1 of 6 residents (Resident #161) whose records were reviewed for Full code status. The facility failed to ensure that nursing staff provided Resident #161, who was listed as a Full Code, CPR, after the resident was reported to LVN C as not breathing, according to professional standards of practice. LVN C failed to verify Resident #161's code status before calling hospice which led to the resident being pronounced dead and CPR not being initiated for approximately 63 minutes after the resident was found to be unresponsive. An Immediate Jeopardy (IJ) was identified on [DATE] at 3:59 pm and the IJ Template was provided to the facility Administrator. While the Plan of Removal (POR) was accepted on [DATE] at 3:05 pm and the immediacy was removed on [DATE] at 5:41 pm, the facility remained out of compliance at a scope of isolated at a level of no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed the residents at risk of not having their wishes known, respected, and implemented in an emergency. The findings included: Review of Resident #161's Admission Record revealed she was an [AGE] year-old female originally admitted to the facility [DATE] with a most recent admitted [DATE]. She had admission diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), moderate malnutrition, breast cancer, chronic pain, and atrial fibrillation (abnormal heart rhythm). Her code status was listed as Full Code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures would be provided to keep them alive). Review of Resident #161's MDS list revealed that at the time of her [DATE] admission, no comprehensive MDS assessment had been initiated. Review of Resident #161's Hospice Clinical Chart revealed that during her intake interview and assessment on [DATE] at 3:52 pm, the resident was a full code but requested DNR paperwork (there was no DNR form located in the resident's EHR during record review) be given to her and her family to fill out. Review of Resident #161's Hospice admission orders dated [DATE] revealed no mention of code status. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #161's Admission Assessment/Baseline Care Plan Summary, initiated [DATE] and signed [DATE], revealed in Section O Code Status that she was a DNR. Review of Resident #161's Physician's Progress Notes revealed no mention of code status in the admission note. Review of Resident #161's care plan dated [DATE] revealed Problem: I have chosen DO NOT RESUSCITATE status. Review of Resident #161's Order Listing Report revealed no order for code status. Review of facility's handwritten 24-hour report log for dates [DATE] and [DATE] revealed Resident #161 was reported as being a DNR. The 24-hour report log sheet dated [DATE] stated Resident #161 re-admit, COPD, moderate protein-calorie malnutrition, hospice. The facility was unable to provide the 24-hour report log for [DATE]. In a phone interview on [DATE] at 2:53 PM with the Hospice Administrator she stated that the hospice company never received a copy of Resident #161's DNR from the family as they were told that the family was going to be providing a copy to the nursing home to keep on file. She stated that the hospice company was told that the family had given a copy of the DNR to facility LVN D on Friday [DATE] when the resident was admitted to the facility and that LVN D either had or was going to enter it into the computer system. She stated that the resident had been living in an assisted living facility but was hospitalized and had a significant decline after being discharged from the hospital and the family opted for her to be placed on hospice services and be admitted to the nursing facility. She stated that when all the hospice paperwork was signed by the family, the family kept the DNR paperwork and assured the hospice employee that they would give the nursing home a copy. She stated that the hospice company offered the family a counseling session with their Social Worker to discuss the DNR paperwork and their options, but the family declined because there was already a DNR in place. The Hospice Administrator stated that on [DATE] a facility nurse called the hospice to notify the Hospice RN M that the resident had passed away. She stated that, according to the notes and discussions she had after the incident with Hospice RN M, Hospice RN M arrived at the facility and pronounced a time of death for Resident #161 at on [DATE] at 3:40 PM. She stated that the facility nurse could not locate the DNR and instructed someone to call 911 and they (facility staff) began chest compressions. In an interview on [DATE] at 3:30 PM with LVN C she stated she called 911 at 4:11 PM on [DATE]. She stated she called 911 after about 30 minutes of searching the facility for a copy of Resident #161's DNR after the she had called hospice to notify them that the resident had expired, and the hospice nurse had already pronounced a time of death. She stated that after the hospice nurse pronounced the resident, she (LVN C) realized she had not verified the resident's code status and when she went to check she found there was no DNR on file for the resident. She stated that she should have verified the code status before calling hospice to pronounce. LVN C stated the resident was on hospice for comfort measures but was listed as a full code was her understanding. LVN C stated that Resident #161's MPOA told her that she had given a copy of the DNR to LVN E on the night before the resident passed away ([DATE]). She stated that there were several family members in the room, including the MPOA, when the resident passed and after hospice pronounced a time of death the family left the facility. She stated that whoever received records for the resident's admission would be responsible for making sure there was a DNR on file. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 10:30 AM with Social Worker, he stated that his role in the code status process was to have a Code Status Discussion with the resident or their representative within 48 hours of admission. He stated the discussion was a simple conversation about what the resident would like to have done if their heart stops while they are a resident, basically CPR or no CPR. He stated he did not get the chance to do the Code Status discussion with Resident #161 due to her admission being after business hours on [DATE] and her passing away on a holiday. He stated he had done a Code Status Discussion with her during her previous admission (,d+[DATE]), and she was a full code. He stated that whoever admitted the resident would have been responsible for getting the copy of the DNR from the family if there was one. He stated if he was the one who takes the DNR from the family he immediately scanned it and uploaded it into the resident's EHR. He stated that he did not have a hard copy DNR book, and he was pretty sure the nurses did not have hard copies of the residents' DNRs either. In an interview on [DATE] at 11:27 AM the Administrator confirmed that facility did not keep hard copies of DNRs on hand in the facility. He stated that all DNRs were kept in resident charts in the facility's EHR and code status was flagged for each resident and that the code status was accessible to all staff with EHR access. In an interview on [DATE] at 04:09 PM ADON stated that when an admission was done, they (staff completing the admission) were supposed to get their own copies of all paperwork including advanced directives. She stated that Resident #161 was a hospice resident, and she feels like they should have provided the facility with the DNR. She stated that the Admission/Readmission Evaluation in the EHR can be initiated by one nurse and finished/signed by a different nurse depending on what time the resident is admitted because of shift change, then the RN signs off on it and there is no way to tell which nurse completed which section. She stated that even if the admission evaluation and the care plan stated that the resident was a DNR, until the facility had the physical copy of the form the resident was considered a full code. In an interview on [DATE] at 04:50 PM LVN D stated he could not remember if he worked [DATE] through [DATE] without looking at a schedule. He stated he did not remember Resident #161 and denied that he was given a DNR for Resident #161 at any time. In a phone interview on [DATE] at 08:55 AM LVN E stated he did not remember Resident #161. He stated the facility had a high amount of resident turnover and if a resident was not long-term it was difficult to remember all the residents. He stated that when he admitted a new resident, he would keep all the admission paperwork at the nurse's desk in a basket for medical records to pick up and scan into the chart. He stated that if he did receive Resident #161's DNR form with her admission paperwork it would have gone into the medical records basket with the other paperwork. He stated that each nurse's station had one of these baskets. LVN E stated all paperwork that the nurses needed scanned into charts went into that basket for medical records. He stated the paperwork in the basket was normally picked up the next day or if it was a weekend, it was picked up Monday morning. He stated that he did not have access to scan documents into resident charts and did not think the other nurses did either. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 11:31 AM Hospice RN M stated she received the call that Resident #161 had passed away at 3:17 pm on [DATE] and it took her a little while to get to the facility. She stated that when she arrived, she assessed the resident and spoke with the family, and she pronounced the resident's time of death as 3:40 pm. She stated that she explained to the family that she would notify the funeral home and make arrangements for the funeral home to contact the family to set up their next steps and that after the family spent a few minutes with the resident they left the facility. She stated that at some point (she was never told what time the call was placed), either ADON or LVN C notified the DON that they were unable to locate Resident #161's DNR and that the DON told them they had to call 911 and begin CPR because without the DNR in hand Resident #161 was considered a full code. She stated that facility staff began CPR just as EMS arrived and then they (EMS) took over. Hospice RN M stated she explained to the EMTs that the resident was pronounced dead at 3:40 pm and had been down since at least 3:17 pm and asked if they could just call their medical director and have them call a time of death, but they refused because there was no DNR available. She stated that the resident's MPOA told her that she had given the facility the DNR [DATE] and that she (MPOA) had personally handed it to LVN D. She stated that LVN C tore the building apart trying to find the DNR form but was not able to locate it. She stated the facility told the family and hospice that they never received the form. In an interview on [DATE] at 12:48 PM with DON she stated that DNRs were scanned into the charts and nurses, management (DON, ADON, Administrator, Social Worker, MDS) had access to the form once it was scanned in. She stated that CNAs had the code status listed on their Kardex (resident information sheet for non-nurses) but did not have access to the DNR form itself. She stated anyone with EHR access could see a resident's code status but not the DNR form. She stated Resident #161 had been a resident in the facility before and had always been a full code in the past, so she stated that the understanding that she was a DNR on her last admission was strange to her. DON confirmed that there were no hard copies of DNR forms kept in the facility. She stated that any prudent nurse would check for a DNR before taking any action in a code situation. She feels that the facility did everything they were supposed to do regarding Resident #161's admission. She stated she was admitted after business hours so the Social Worker who normally asked the advanced directive questions was not here to do it. She stated that the hospice administrator told her (DON) that there was a copy of the MPOA form so she believed maybe the family thought that was the DNR. DON stated there was no in-service done for the staff after the incident because she was not aware that the resident had been deceased for that amount of time before 911 was called and CPR was started and that there was so much confusion regarding her 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 Note: The nursing home is disputing this citation.	In a phone interview on [DATE] at 4:29 PM Resident #161's MPOA stated she did not have a copy of the resident's DNR because the copy she gave the LVN E was the original document with a carbon copy attached. She stated that a hospice agent had taken a picture of the DNR with a cell phone for hospice records (surveyor was not able to verify this with any hospice employee). She stated that she gave the DNR to LVN E on [DATE] while he completed Resident #161's admission to the facility. She stated the hospice company had given Resident #161 the DNR paperwork to fill out. MPOA stated that after the resident completed the form, she (MPOA) and two other family members signed as witnesses on [DATE] and then gave the form to LVN E on [DATE]. MPOA stated that on [DATE] she and several family members were in the room when Resident #161 passed at approximately 3:20 pm. She stated she ran to get LVN C, who came to assess the resident, and that LVN C confirmed that Resident #161 had passed. She stated that LVN C then left the room to call hospice. MPOA stated that Hospice RN M arrived a short time later (she was not sure of the exact time) and pronounced time of death for the resident at 3:40 pm. MPOA stated that the family left the facility after Hospice RN M pronounced Resident #161 deceased . She stated she was called by Hospice RN M a while later to advise her that the facility staff could not locate the DNR and were calling 911 and starting compressions (MPOA was unable to give any exact times for phone calls). She stated that after the EMTs arrived and had taken over CPR, Hospice RN M had her (MPOA) on speaker phone telling the EMTs that she was the MPOA and to stop CPR, but they refused because they did not have the DNR and could not prove she was who she said she was over the phone. She stated she was told by Hospice RN M that the EMTs called their physician for orders to stop CPR and a new time of death was given. In an interview on [DATE] at 5:25 PM LVN F (6a-6p) Stated she has a cheat sheet that she worked off when doing admissions, but she stated that a lot of the admission tasks will queue to be done in the EHR system. She stated that the Social Worker was normally the person responsible for the Code Status Discussion but anyone who did an admission had access to that assessment and was able to complete it. She stated that she believed that the Code Status Discussion flagged in the UDAs (user-defined assessments) for nursing staff a few days after admission if it had not been completed. She also stated that if a resident was admitted with a DNR in hand she would not complete the Code Status Discussion. She stated that if she admitted a resident after hours or on a weekend that expressed interest in becoming a DNR she would bypass the Code Status Discussion and go straight to filling out the DNR form, or if a resident that could not communicate was declining, she would call the family and have the code status discussion with them. She stated she would never wait on the Social Worker to have the code status discussion. In an interview on [DATE] at 6:00 PM RN G (6p-6a) stated there was a list of assessments that had to be completed for an admission. She stated that management would let them know they were going to get an admission so she would have everything she needed to do ready; hospitals should give a report so she should know basic information about the resident before they arrived. RN G stated when a new resident arrived the first thing, she checked was code status because even a DNR outside the facility was considered a full code in the facility until they were assessed by the Social Worker. She stated that if a new resident came in with a DNR form in hand she would honor the DNR and notify the DON and document that she received the DNR even if the code status had not yet been set to reflect it. She stated she have the code status discussion with residents, but she has never done the actual assessment in PCC and was not aware it was there. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a follow-up interview on [DATE] at 8:50 AM LVN C stated that she received report from LVN E on [DATE] at 6:00 AM that Resident #161 had been admitted to the facility to die and was a DNR. She stated that she was working Monday through Thursday only during that time due to her school schedule and another nurse was working only weekends, so [DATE] was the first day she had been responsible for the care of Resident #161. She stated that when the family called her into the room, they told her that Resident #161 had stopped breathing. She stated she assessed the resident for a pulse and breath sounds and after finding none, she told the family that she would notify hospice then left the family to be with the resident. She stated that she called to notify hospice that the resident had expired. She stated that the family left almost immediately after Hospice RN M arrived and pronounced the time of death at 3:40 pm. She stated that she was uncertain who realized that the resident did not have a DNR on file and was listed as a full code. She stated that the ADON, who was working the opposite hall, called the DON and notified her that the Resident #161 did not have a DNR on file and was listed as a Full Code, but had been pronounced dead at 3:40 pm by Hospice RN M. At approximately 4:10 pm the ADON came to her nurse's station and notified her that the DON had said that because there was no DNR on file they had to start CPR and call 911. LVN C stated that in the nine hours she was responsible for Resident #161 the family never said anything to her specifically about the resident being a DNR. She did recall the family asking questions about how long it would take for the resident to pass and what to expect and requested that she call the hospice chaplain to come visit with them. She stated that in her opinion the family was aware the resident's death was imminent and their priority was making sure she was comfortable and not suffering in her last hours. She stated she was not aware that she could complete the Code Status Discussion Assessment with new admissions. She stated that she has initiated the DNR form with residents before but was not aware that the form would be honored before the physician had signed it. She stated that she does not have access to scan documents into the resident EHRs so even if she was given a DNR or other form by a resident/family on admission it would have to wait until management or medical records staff was available to upload the document. She stated that when she was looking for Resident #161's DNR form she was unable to find paper copies of any of her admission paperwork in the building. Review of Resident #161's Hospice Client Coordination Note Report revealed the following: Triage Note dated [DATE]: LVN C called triage nurse [DATE] at 3:17 pm to report Resident #161 had expired with family present. Hospice RN M was notified at 3:22 pm and was en route to the facility. Narrative Note dated [DATE] by Hospice RN M: Patient resting in bed with no breaths noted. HSN auscultated (listened with a stethoscope) for over one minute apical (over the heart). No pulse noted. TOD 1540 (3:40 pm). Funeral Home called 1600 (4:00 pm). CPR started at 1620 (4:20 PM) by paramedics due to facility not able to produce DNR in hand. MPOA called. She wants CPR stopped but per paramedic they cannot stop CPR over the phone with MPOA. Facility staff searching for DNR called maintenance to open the office to find the paper copy. Paramedics continue CPR until 1647 (4:47 pm). HSN filled out paperwork for mortician and facility. Body released to funeral home at 1705 (5:05 pm). Review of Resident #161's EMS Patient Care Record dated [DATE] revealed the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Incident Narrative: Upon arrival the patient presented in the supine (on back) position in bed. NH staff were ventilating the patient with a BVM. NH staff initially informed EMS that patient stopped breathing at approximately 16:00 (4:00pm) today. EMS palpated (felt with fingers) the patient for a pulse, and none were noted. EMS moved the patient to the floor without incident using a patient carry. EMS began manual compressions and ventilating the patient. A NH employee entered the room and informed EMS that the patient has a DNR, but they are unable to locate it. EMS informed the employee that we must see a valid, physical copy of the DNR in order to cease resuscitative efforts. The NH employee never returned with a physical DNR. EMS attached multi pads (adhesive pads to detect heart rhythm) and the patient's rhythm was asystole (no detectable heartbeat) and remained asystole for the duration of the incident. IO access (technique in which the bone marrow cavity is used as a non-collapsible vascular entry point for delivering fluid or blood products) was gained, and EMS began administering LR (IV fluid). EMS inserted [NAME] (artificial airway used to help ventilate the patient) and attached the ETCO2 monitor and accuvent (attachment to monitor flow of air while ventilating patient). EMS proceeded to follow asystole protocol with pulse checks every 2 minutes and administering epinephrine every ,d+[DATE] minutes. EMS administered D10 (IV fluid). EMS obtained a 4-lead EKG. Approximately 15 minutes into the call a NH employee entered the room and informed EMS that the patient had stopped breathing at approximately 15:17 (3:17 pm) today. After approximately 25 minutes of CPR, EMS contacted medical control and informed physician on call of the details and interventions performed and the physician directed EMS to cease resuscitative efforts and called the time of death at 16:47 (4:47 pm) on [DATE]. EMS acquired a signature from the NH staff. EMS cleared the scene and returned to service. In an interview on [DATE] at 1:15 PM Regional Director of Clinical Services stated the facility did not have a CPR policy. She stated the staff that were CPR certified rely on their training to know when to perform CPR. She stated she was the instructor for staff at the facility and they know when to do CPR. In a phone interview on [DATE] at 10:07 AM Medical Director stated that the facility does address code status on admission. She stated that if the resident was a full code, the facility was very quick to react to the situation. Medical Director stated that in a code situation the staff did compressions and ventilation until EMS arrived and took over resuscitation efforts. She stated that if the resident is a DNR the facility was to honor that and if the resident wished to become a DNR the Social Worker was to assist them in completing the paperwork. She stated that any licensed staff would be able to have the code status discussion with a resident or their representative and if there was an admission on a weekend or holiday the discussion still needed to happen, and it should never be put on hold until the Social Worker came back to work. Medical Director stated that she had not been made aware of the situation regarding Resident #161 and stated that the fact the resident had an MPOA would negate the need for a DNR. She stated that the DON should have instructed the facility nurses to contact the MPOA and get permission to not do CPR after staff realized the DNR was not in the facility rather than instructing them to call 911 and begin CPR. She stated that this was poor advise on the part of the DON. She stated that there was a clear lack of judgement on everyone's part. Review of blank, undated facility form titled Admission Checklist - Morning Clinical Meeting form revealed: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. During 48-hour care plan meeting, social worker or designee will review code status with resident and/or resident representative This discussion is documented in the Code Status Discussion UDA. 3. Any Advanced Directives such as Medical Power of Attorney or other documents are uploaded to 'EHR' under the Miscellaneous tab under 'Advanced Directives. 4. Follow up with the resident quarterly and upon change of condition to review/clarify code status, Advanced Directives, Medical Power of Attorney to ensure that what the resident has in place is still consistent with what he/she wants. IJ was identified due to the above failures on [DATE] at 3:59 pm, and the IJ Template was provided to the Administrator. The Plan of Removal was accepted [DATE] at 3:05 pm and included: F578: The facility failed to have a system in place to ensure residents' Advanced Directives are accurately addressed and assessed at time of admission. Identify residents who could be affected. - All residents have the potential to be affected. - Facility census on [DATE] was 55. In-Service Conducted - All staff will be in-serviced on how to obtain the code status for all residents by utilizing the DNR code book found at each nurse's station. - DON, ADON, Regional Nurse Consultant will provide the training beginning [DATE] and continued until completed on [DATE] for current employees and all new hires. - Verbal understanding will be utilized for knowledge retention. Implementation of Changes - DNR and full code status audit was completed by Regional Nurse Consultant and DON on [DATE] for accuracy in 'EHR'. There were no issues identified on this audit, so no corrections were needed . - DON/ADON/Social Worker will audit once weekly for 3 months for 'EHR' accuracy. This audit was 100% of all current residents to include new admissions. - Code Status discussion will be conducted by social worker during business hours Monday through Friday and after 5 pm or weekends, holidays, charge nurses assigned a new admission will be completing code status discussion with residents or resident representative. - Weekend supervisor will verify completion of code status. (continued on next page)

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	676031	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Nursing and Rehabilitation	4343 Oak Grove Blvd San Angelo, TX 76904

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- Full code or DNR will be put in 'EHR at that time and or assisting with DNR paperwork. Administrator/DON/weekend RN supervisor will verify completion of the discussion daily and accurately documented in 'EHR' beginning [DATE]. - DON/ADON will review code status discussion after hours daily including holidays for new admissions beginning [DATE]. - All new admissions on weekends will be addressed in the morning meeting for accuracy of code status and confirm code status and resident rights, documented in 'EHR', DNR uploaded in 'EHR' and DNR binders at each nurse's station. - In-service will be conducted starting today regarding code status discussion and after-hours process. DNR binders will be at both nurses' stations. - DNR binders are to be easily accessible for new DNR requests and filled out by the charge nurse if requested. - DNR binders are the binders that will contain the completed Out of Hospital DNR for all residents with advanced directives. - Code status will be reviewed quarterly at the care plan conference. - Nurses will be made aware of code status changes by communicating via the 24-hour report which contains all new telephone orders, verbal shift change discussion daily on each shift, social worker may also communicate the change in a code status. Monitoring - DON/ADON will review code status discussions Monday through Friday and weekend supervisor will be monitoring for accuracy. - Any negative outcomes will be reported to the QAPI committee monthly for 3 months and if no concerns, consider it resolved. Involvement of Medical Director - The Medical Director was notified about the immediate jeopardy on [DATE]. The Survey Team conducted POR verification [DATE]. In interviews conducted on [DATE] from 12:04 pm to 4:30 pm, 8 nursing staff and the Director of Rehab confirmed they received in-services on the DNR books, CPR, the Code Status Discussion, and DNR/Code Status paperwork and were able to give the location of the DNR books and how to find a resident's code status in the EHR. Review of facility in-service dated [DATE] titled DNR Book, CPR, Code Status Discussion revealed: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. Codes Status Discussion will be done on admit and after-hours (weekends) by charge nurses. Social Worker will do them M-F. 2. DNR books on both nurse's stations contain DNR (blank) to fill out upon request. 3. Code status is located under care profile and 2nd confirmation is Code Status book. 4. All nurses must have American Heart or Red Cross for CPR card. If you do not have these, get one ASAP or certification. Review of facility in-service dated [DATE] titled DNR Code Status/Paperwork revealed: 1. DNR CODE BOOK - where - nurse's station at both ends with all current residents; conta[TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45399 Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that ensure the accurate administering of all drugs to meet the needs of the residents, for 1 (hall 100 medication cart) of 2 medication carts inspected for medication storage. The hall 100 medication cart had expired medications and wound care supplies. This failure could place residents at risk of receiving medications that were expired and not produce the desired effect. The findings were: During an observation on 2/27/24 at 2:20 PM of Hall 100 medication cart with LVN B revealed: 1- 86 gram tube of antimicrobial wound gel, expired 12/8/2022. 8- 3 milliliter vials of sodium chloride inhalation solution expired 7/8/2022. 1-5X9inch Xeroform Petrolatum dressing, expired 2/2023. During an interview on 2/27/24 at 2:20 PM LVN B stated it was her cart and she was responsible for checking her cart for expired medications. LVN B stated expired medications may not have benefits for residents and therefore should not be used. During an interview on 2/27/24 at 4:00 PM the ADON stated nurses were in charge of checking their carts for expired medications. The ADON stated that it is important to throw out expired items because expired medications and expired wound care supplies did not get the desired effect. During an interview on 2/27/24 at 4:30 PM the DON stated that it was the nurses' duty to monitor their carts for expired medications and discard them if not dated or expired. DON stated expired supplies may not provide the desired effect. The DON failed to provide a policy on medication storage and labeling, upon surveyor request on 2/27/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48593 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure food items in the facility's only dry storage were dated and sealed appropriately. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observations of the facility's kitchens only dry storage on 02/27/2024 at 10:00 am revealed the following items were not sealed, labeled, or dated: 1 package of pancake and waffle mix opened, in an opened resealable bag partially dated 8/4. 1 package of Creamy Wheat opened, in a resealable bag, partially dated 12/3. Interview with the Dietary Manager (DM) on 02/29/24 at 03:08 PM revealed he was not aware that food that had been opened was required to be dated, labeled, and sealed. DM stated that foods in the dry storage are to be dated upon receiving the items and dated with an Open Date when the item is opened. If the item needs to be in a bag the bag the item is placed in should be sealed, dated, and labeled if the product cannot be visualized through the bag. Dietary manager stated items that are found open and undated will be thrown away. Dietary manager stated items that are left open are at risk of contaminants which could result in the food being cooked with something else in the foods that is not intended. DM stated the items could be contaminated with other food products or non-food products. Review of the facility policy titled Food Storage with no date, states in part store opened and bulk items in tightly covered containers. All containers must be labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45399 Based on observations, interview and record review the facility failed to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable infections for 1 of 3 residents (Residents #1) reviewed for infection control, in that: LVN B failed to change her gloves after they became contaminated during incontinent care while assisting Resident #1. LVN B failed to wash or sanitize her hands prior to putting on gloves and after removing them during incontinent care while assisting Resident #1. These failures could place residents at risk of urinary tract infections. Finding include: Record review of Resident #1's admission record dated 02/29/24 indicated she was admitted to the facility on [DATE]. Diagnoses included fracture of acetabulum (hip socket), dementia (progressive loss of intellectual functioning), major depressive disorder (mood disorder) and anxiety disorder (disorder characterized by feelings of worry, anxiety, or fear). She was [AGE] years of age. Record review of Resident #1's MDS assessment dated [DATE] indicated in part: Bladder and Bowel: Bowel and bladder Continence = frequently incontinent. Record review of Resident #1's care plan dated 02/20/2024 indicated in part: Focus: Resident is incontinent of bowel and bladder related to confusion/dementia. Goal: Residents risk of septicemia (life threatening complication of an infection) will be prevented via prompt recognition of symptoms of urinary tract infection. Interventions: Clean perineal area (the patch of skin between genitals and anus) thoroughly after each episode of incontinence. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/27/2024 at 10:44 AM LVN B entered Resident #1's room and Resident #1 stated she needed her brief changed due to a bowel movement. LVN B closed the door and pulled the curtain for privacy. LVN B pulled the covers down and then donned gloves, failing to perform hand hygiene prior to putting on gloves., LVN B removed the front of the brief and rolled it in on itself. LVN B told Resident #1 to roll herself to her left side, LVN B wiped Resident #1's buttocks with wet wipes from clean to dirty. LVN B placed the soiled brief on Resident #1's wheelchair. LVN B stated that she was aware that she should have placed the soiled brief in the trash can and shrugged her shoulders. LVN B placed a clean brief under Resident #1 and told the resident to roll herself to her back. LVN secured the brief and covered the resident with her blanket. LVN B failed to remove soiled gloves and do hand hygiene prior to touching residents clean brief and clean blankets. LVN B then removed her soiled gloves and stated that she most likely did everything wrong but she did not know the correct steps for changing a brief, since the CNA's usually do it. LVN B stated that performing incontinent care correctly and changing gloves is important to prevent infections. During an interview on 02/29/2024 at 10:42 AM the ADON said that the DON and herself trained staff and performed in-services to ensure they could provide appropriate care to residents. The ADON said staff were expected to follow policy for perineal care. The ADON said improper peri care could lead to cross contamination. During an interview on 02/29/2024 at 11:56 AM DON was made aware of the observation. DON stated that if the nurse did not know how to perform incontinent care, she should not have done it. DON acknowledged it was a concern and there would be more training regarding handwashing and glove changing. Record review of the facility's policy titled Handwashing/Hand Hygiene and dated 08/2019 indicated in part: This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: When hands are visibly soiled. Use an alcohol-based hand rub containing at least 62% alcohol or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before and after coming on duty; before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care. Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Single use disposable gloves should be used before aseptic procedures; when anticipating contact with blood or bodily fluids and when in contact with a resident or the equipment or environment of a resident who is on contact precautions. Record review of the facility's policy titled Perineal Care revised February 2018 indicated in part: The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the residents skin condition. Wash and dry your hands thoroughly and put on gloves. Wash perineal area, wiping from front to back. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ask resident to turn to side. Wash rectal area, wiping from base of the labia towards and extending over the buttocks. Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash and dry your hands thoroughly or use hand sanitizer. Put on clean gloves and clean brief. Reposition the bed covers, make resident comfortable. Wash and dry hands thoroughly.