STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676222	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	430 Old Austin Hwy Bastrop, TX 78602

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 17141 Based on interview and record review the facility failed to ensure the resident's right to formulate an advance directive for 1 of 3 Residents (Resident #3) whose records were reviewed for DNR code status. The facility failed to ensure nursing staff followed emergency protocol and failed to ensure staff did not provide Resident #3, who had a DNR in place, CPR, after the resident became unresponsive, without a pulse and respirations, according to professional standards of practice. The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This deficient practice could deny a resident's right to experience the dying process as they had predetermined with their advance directive, resulting in a resident having to experience the death process twice. Findings include: Review of Resident #3's undated face sheet reflected an [AGE] year-old male who was readmitted to the facility on [DATE], with an initial admitted [DATE], with diagnoses including unspecified dementia (a progressive brain condition that can cause issues with thinking, behavior, and memory), type II diabetes, heart failure, muscle wasting and atrophy (decreasing size). Review of Resident #3's Annual MDS assessment, dated [DATE], reflected a BIMS of 11, indicating a moderate cognitive impairment. Review of Resident #3's care plan, revised [DATE], revealed an area of focus included Resident #3 had a DNR. The goal of the of the DNR focus being, Facility will comply with resident/family wishes. Interventions included If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification. Review of Resident #3's physician orders for [DATE] revealed an order for DNR, dated [DATE]. Review of Resident #3's Out-of-Hospital Do-Not-Resuscitate Order revealed it was signed on [DATE]. The order contains signatures of two witnesses, a physician and Resident #3. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #3's progress note, written by LVN A, dated [DATE] revealed the following: CNA staff was screaming this nurse's name at the hallway to come to resident's room. When this nurse arrived. Resident was sitting in the bathroom commode unresponsive. This nurse moved resident to the to the floor, started CPR, applied oxygen, and activated 911. Stopped CPR as soon as staff was informed that the resident is DNR. Resident pulse started to come back some minutes before EMS arrived. Resident was transferred to (hospital name) by the EMS. Continued review of the notes revealed on [DATE] it is noted Resident #3 remained in the hospital. During an interview on [DATE] at 9:51 AM, LVN A stated he was Resident #3's nurse on [DATE]. He stated he heard CNA J screaming his name, so he went to where she was. Once there he saw Resident #3 on the toilet with CNA J and MA L trying to hold the resident, so he was sitting upright. LVN A stated he and MA L assisted Resident #3 to the floor and he sent CNA J to get a pillow, so they did not injure Resident #3's head while putting him on the floor. He stated he asked CNA J to go get the crash cart (cart carrying equipment used for resuscitation). He checked Resident #3 for a pulse and respirations and there was none. LVN A stated he asked MA L to find the resident's code status, but she said she did not know how. He then asked MA L to take over the CPR so he could check Resident #3's code status himself. LVN A said she was crying and said she did not know how to do CPR either. He stated he asked CNA J to go get the nurses cart and the other nurses. He stated he did not know Resident #3's code but his instinct was to do CPR as the resident was turning blue. LVN A stated he realized Resident #3 was breathing when the resident said, help me. LVN A stated he then went and checked the code status and saw Resident #3 had a DNR. LVN B was outside the room and had called 911. LVN A stated by the time EMS arrived, which was not more than a few minutes later Resident #3 was breathing and coming back alive. He stated EMS did not do CPR; they just bundled Resident #3 up and took him. LVN A stated there is no way that a nurse can memorize every resident's code status and it is not unusual for the status to change day from day. LVN A stated that the nursing staff received an in service saying to know the code before starting CPR. He stated the CNAs were trained on where the code status is located and to check the status while the nurse is checking for respirations, pulse and is positioning the resident. LVN A stated it takes less than a minute to log in to the EHR and click on the resident's picture. LVN A stated following the rule of checking before starting CPR will ensure the resident's wishes are followed. During an interview on [DATE] at 12:20 PM, MA L stated she was next door to Resident #3's room putting in eye drops for another resident. She stated she heard CNA J call out for help. MA L stated she found CNA J trying to hold up Resident #3 on the toilet. She got on the other side of Resident #3 to help. She stated LVN A came in the bathroom, and they lowered Resident #3 to the ground, putting a pillow under his head. MA L stated the nurse checked for respirations and a pulse but there were not any. She stated she started freaking out. MA L said there was not any talk about what Resident #3's code status was, and she was not asked to check, but LVN A started CPR right away. MA L stated CNA J started to get stuff the nurse was asking for while he was giving CPR. MA L stated she did not assist with the CPR but did assist with applying oxygen that someone had brought. MA L stated she believes it was LVN B who told LVN A that Resident #3 was a DNR. MA L stated she was uncertain if LVN B told LVN A before or after EMS arrived. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:57 PM, CNA J stated she had heard an emergency bathroom call light going off, so she responded. She stated she found Resident #3 was sitting on the toilet, slumped over and unresponsive. MA L, who had been close by, responded to her calling for help. CNA J stated LVN A was in the room soon after. She stated LVN A asked her to hand him a pillow and go get the crash cart. She ran to the crash cart and took it back to Resident #3's room. Once there LVN A then asked her to get the oxygen which was in the room next door. After she got the oxygen to the room, LVN A told her to go get the nurse's cart. CNA J stated she had no idea how long of a time this had taken to run and get these things, but LVN A was applying pressure during this time and asked her and MA L to apply the oxygen nasal cannula. CNA J stated LVN A had not asked her to find out Resident #3's code status. She did not see LVN A applying CPR, just applying pressure to Resident #3's chest. CNA J stated at the time she was having a panic attack and did not remember how Resident #3's code status was determined to be DNR. CNA J stated since the incident with Resident #3 she has received in servicing and knows if this situation happened again, she would notify the nurse and immediately look up the code status. During an interview on [DATE] at 2:05 PM, LVN B stated she had heard MA L yelling for help and ran over to Resident #3's room. She stated she got to the room soon after LVN A and saw Resident #3 on the floor. LVN B stated she heard LVN A yell for someone to get the crash cart. LVN B said by that time she was already calling 911, so CNA J got the crash cart. LVN B stated she stepped out of the room so she could hear what 911 was saying. LVN B stated she had seen that LVN A started CPR before she left the room. LVN B stated she does not remember who announced Resident #3 had a DNR, but it had been discovered when someone, she thinks another nurse, printed out the paperwork to give to EMS. LVN B stated soon after Resident #3 received CPR the facility had an in-service reminding all where the code status was available and that the nurse needed to know prior to giving anyone CPR. During an interview on [DATE] at 1:25 PM, with CNA K stated she works as needed on the overnight shift usually. She explained she did not work the night Resident #3 was found unresponsive. CNA K stated all of them, CNAs and nurses had been in-serviced with a reminder of where to find a resident's code status. CNA K stated CNAs were told to look up the code status in addition to or for the nurse they notified. She stated when they open a resident information, which they do most days to chart, the status is at the top of the page. Interview on [DATE] at 3:30 PM, with LVN C stated he had not worked with Resident #3 but had received the in-service last month regarding code status. He is clear on where the information is in the EHRs and knows to look before performing CPR on any resident. LVN C stated it is the first screen you see when you open the resident's record. He stated he no longer sees agency staff (paid by a private employer, who is contracted with the facility to fill vacancies) and that all staff nurses received the in service. LVN C stated he recently was given a mock drill. He stated he did not know what was happening, that a staff came up and told him a resident was down. He said he grabbed the crash cart and ran down to the resident's room. On the way he saw an MA in the hall and asked her to look up the resident's code status. LVN C stated once he got to the room the DON was there and asked him what all he had done and what he would do from that point on. LVN C stated the crash cart contains a list of residents that have DNRs. During an interview on [DATE] at 1:50 PM, with CNA D stated she did not work on Resident #3's hall but they all have to ability to see all resident's information so she would be able to look up a code status. CNA D stated the code is on the first page you open. The CNA would go to the kiosk on each hall, sign in, and click on the resident's picture to get the information. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:00 PM, CNA E stated she had received an in-service about looking up a resident's code status. She stated they are to notify the nurse, then look up the status themselves. If the nurse does not know or ask you should be able to tell them. CNA E stated they use the kiosk located in the hallway. She said each kiosk has the information for all residents in the facility. When CNA E had been asked by the writer to pull up a random resident's information, that was not on her hall, she had been able to do so in 35 seconds. During an interview on [DATE] at 1:04 PM, CNA F stated she had received an in-service about looking up a resident's code status. She stated they are to notify the nurse, then look up the status, so they know themselves. CNA F stated they tell the nurse when they respond to the call or while they are assessing the resident. She stated every CNA has a code they use to get into any of the kiosks. They use it daily to chart on the residents they are assigned. When CNA E had been asked by the writer to pull up a random resident's information, that was not on her hall, she had been able to do so in 20 seconds. During an interview on [DATE] at 3:28 PM, NA G, stated she had been newly hired. With her training she had been taught that if they find a resident unresponsive, they run to notify the nurse, if someone else is available to stay with resident. If not they holler out, then look up the resident's code status. When NA G had been asked by the writer to pull up a random resident's information, that was not on her hall, she had been able to do so in 42 seconds. During an interview on [DATE] at 3:34 PM, CNA H stated she had received the in-service. She stated she was clear that they were to notify the nurse, then look up the resident's code. CNA H stated the nurse will probably already know but they make sure to have the information in case the nurse asks or does not know. When CNA H had been asked by the writer to pull up a random resident's code, who was not on her assigned hall. She initially pulled up the wrong hall and did not see the resident's picture. She stated she had forgotten the resident had recently changed rooms. CNA H then went to a different hall listed in the program, on the kiosk, and found the resident's information within 47 seconds, total time from being asked initially. During an interview on [DATE] at 2:05 PM, the facility On-Call NP stated she did not work with Resident #3 but is the NP available today. The NP stated when working with any resident the nurse should know the resident's code status. If the resident has a DNR status and is found unresponsive nothing should be done. The NP stated not following the resident's code status means that as a nurse you do not have authorization to resuscitate the resident. During interviews on [DATE] at 9:00 AM and [DATE] at 2:45 PM, with the Acting DON revealed LVN A should have known Resident #3's code status before initiating CPR. As a result of not doing that there is a possibility of not honoring the residents wishes. The acting DON stated in services were given, during which each nurse had to demonstrate where the code status is located. The status was on the opening page in the EHR after the residents' picture is clicked. She stated unannounced drills had been performed with the nursing staff to ensure they implemented knowing the code before any resuscitative measures. The Acting DON stated CNAs were not supposed to give CPR as they are not required to have certification. She stated the CNAs are told to call a nurse. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:49 AM, with the CN stated they recognized the issue right away after the incident. She feels it was not a system problem, that it was an isolated incident. CPR should have not been given by LVN A. The CN stated they started in-servicing and asking for return demonstrations. All the nurses knew prior to the in-services how to get to the code status. The CN said they had them all demonstrate and state the process when responding. She stated the change they made was making sure nurses were aware to get the information before starting CPR. During an interview on [DATE] at 12:02 PM, Resident #3's FM was contacted. The FM stated they were aware CPR had been performed on Resident #3 after he was found without a pulse. The FM stated LVN A had called them after Resident #3 was sent to the hospital. FM stated the facility should not have done CPR and should not have sent Resident #3 to the hospital. FM R became upset and asked the caller to call another FM to talk to. During an interview on [DATE] at 12:13 PM, with Resident #3's FM was contacted. The FM stated they were upset because by performing CPR they went against what he wanted. Resident #3 had to live another 4 days in the hospital. FM stated they were told at the hospital there was nothing to be done to help Resident #3. The FM stated he was suffering, having strokes repeatedly. Resident #3 was not able to eat or drink and he was unable to communicate with the family but would moan and said help me repeatedly. The FM said it was very hard to see him like that especially because there was nothing they could do to help him although he kept asking. During an interview on [DATE] at 2:00 PM, with the facility AA revealed it had been recognized that the advance directives were not implemented correctly. The AA stated they were not involved at the time Resident #3's death had occurred but had reviewed the information and corrections. The facility AA believed it was not systems issue; it was one nurse. The facility AA stated LVN A is a good nurse, and they worked with him and do not believe this will ever occur again. Nursing and CNAs have all been re-in-serviced, and a lot of code drills were conducted to make sure everyone is on the same page. The expectation would be that the staff verify the code status and go the direction the resident's code status states. If a resident has a DNR, they would expect the staff to honor their wishes and let them be. CPR and calling 911 would not be honoring their wishes. Review of the facility policy, Cardiopulmonary Resuscitation, dated [DATE], revealed It is the policy of this facility to adhere to residents' right to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR). Policy Explanation and Compliance Guidelines: 1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR. 2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition). (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. CPR certified staff will be available at all times. 4. Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in- person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in-person skills demonstrations to obtain certification or recertification is also acceptable. Review of the facility policy, Communication of Code Status, dated [DATE] revealed It is the policy of this facility to adhere to residents' right to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a residents' code status to those individuals who need to know this information. Policy Explanation and Compliance Guidelines: 1. The facility will follow facility policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an Advance Directive. 2. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will clearly documented in the physician orders section of the medical record. Examples of directions to be documented include, but are not limited to: a. Full Code b. Do Not Resuscitate c. Do not Intubate d. Do not Hospitalize 3. The nurse who notates the physician order is responsible for documenting the direction in all relevant sections of the medical record. 4. In the absence of an Advance Directive or further direction from the physician, the default direction will be full code. 5. The presence of an Advance Directive or any physician directives related to the absence or presence of an Advance Directive shall be communicated to Social Services. 6. The residents code status will be reviewed at least quarterly. Review of the facility's Ad-Hoc QAPI agenda, dated [DATE], reflected the ADM, DON, MD, SSR, MR and 6 other non-titled staff were in attendance. They discussed communication of code status, CPR and where to access 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	Review of an in-service entitled Looking up Code Status in PCC/POC, dated [DATE], reflected staff from all shifts were reeducated on the facility's code status definition and the location in the resident chart in PCC/POC and EMR. Review of an in-service entitled Communication of Code Status and CPR, dated [DATE] reflected all shifts were reeducated on the facility policy that only CPR certified employees can perform CPR and Before initiating CPR, code status must be verified. DNR binder containing all patients who are DNR is on the crash carts, and also in PCC. If someone is needing CPR, one staff member stay with resident, one staff member get the crash cart and verify code status. The in-service noted nursing staff not in attendance were given the in-service by phone. Review of an in-service entitled Return Demonstration of where to Access Patients code status, dated [DATE]. The in-service training session contained, nursing staff performed a return demonstration of where they go to in PCC to access a patients code status. There were forty-five signatures on [DATE]. Review of Code Blue Mock Drill evaluations, from [DATE] - [DATE], reflected all 47 participants participated in the drill evaluation containing a checkoff sheet for resident scenario which includes: First person arrives at the scene Resident checked for responsiveness Resident checked for breathing Resident checked for pulse Determine code status Activates emergency response and asks for crash cart/AED/EMS Leader Arrives Leader directs staff to call 911 Leader ensures that notifications are made (MD, RP) First responder arrives at scene Patient prepared for CPR with bed flat & backboard in place Patients responsiveness and breathing checked CPR initiated Adult compressions (,d+[DATE]) full recoil Adult Breaths (,d+[DATE]) visible chest rise) (continued on next page)

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