| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676388 | A. Building<br>B. Wing | 08/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Pavilion at Creekwood | 2100 Cannon Dr<br>Mansfield, TX 76063 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45831<br><br>Based on observation, interview, and record review, the facility failed to protect the residents right to request, refuse, and/or discontinue treatment for one (Resident #1) out of six residents reviewed for advanced directives, in that:<br><br>The facility failed to honor the rights of Resident #1's wishes to die a dignified death by failing to honor a signed OOH DNR order on [DATE] at 07:42 pm when LVN A failed to inform EMS of Resident #1's DNR status and a full code was initiated to include CPR for approximately 43 minutes when Resident #1 became unresponsive.<br><br>An Immediate Jeopardy (IJ) was identified on [DATE] at 03:25 PM. The IJ template was provided to the facility on [DATE] at 03:41 PM and signed by the Administrator. While the IJ was removed on [DATE] at 1:25 PM, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal.<br><br>This facility failure placed residents at risk of not having their rights honored, to include pain, fractures, psychological and physical harm.<br><br>The findings included:<br><br>Record review of Resident #1's undated electronic face sheet reflected she was a [AGE] year-old female that admitted to the facility on [DATE]. Her diagnoses included: anxiety disorder (intense, excessive, and persistent worry and fear), cognitive communication deficit (difficulty with thinking and how someone uses language), dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), cerebral infarction (disrupted blood flow to the brain), chronic obstructive pulmonary disease (damage to the lungs that block airflow that makes it difficult to breathe), gastro-esophageal reflux disease (stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). Resident #1's electronic face sheet also reflected she had a directive for Do Not Resuscitate (DNR) status. Further review revealed Resident #1 expired on [DATE].<br><br>Record review of Resident #1's MDS assessment dated [DATE] reflected she scored a ,d+[DATE] on her BIMS (brief Interview for mental status) which signified she was mildly impaired related to her diagnosis of dementia. She had a reduced ability to understand others and to be understood. She required one-person physical assistance with her ADL's.<br><br>(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 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's comprehensive care plan revised on [DATE] reflected Problem: Resident request code status of DNR, Goal: Status will be maintained over the next 90 days, Approach: Inform staff of code status. Monitor for decrease in change of condition, report to MD and responsible party.<br><br>Record review of Resident #1's Physician Order Details dated [DATE] reflected Code Status: DNR.<br><br>Record review of Resident #1's OOHDNR revealed it was signed on [DATE] by Resident #1, FAM A, the SW and the MD.<br><br>Record review of Resident #1's progress notes written by the SW dated [DATE] at 03:50 PM, reflected SW, ADON, Activities Director, and Dietary met with [FAM A] to complete a care plan meeting. Code status is a DNR.<br><br>Record review of Resident #1's progress notes written by LVN A dated [DATE] at 09:03 PM, reflected Summoned to [Resident #1] room, [Resident #1]'s eyes were bulging, and she was wheezing and yelling help me help me. [CNA A] reported that [Resident #1] had food stuck in her throat and was choking. [LVN A] told [Resident #1] to cough so as to let the food out, but [Resident #1] couldn't. [LVN A] gave [Resident #1] back blow and suctioning but no respite. [Resident #1] stop responding and was turning blue, [Resident #1] was placed on O2 running @3LNC then [LVN A] started the Heimlich maneuver and called Code Blue. The paramedics was called, and [Resident #1] was sent to the ER. Vitals taken: 98.0 F (temperature), 20 (respiratory rate), 92% (pulse oximetry), ,d+[DATE] (blood pressure), 89 (pulse). MD, RP, DON notified.<br><br>Record review of Resident #1's progress notes written by LVN A dated [DATE] at 09:03 PM, reflected [LVN A] received a call from the [Company] police department and wanted to know what happened to [Resident #1]. [LVN A] explained what transpired and was informed that [Resident #1] had passed away. The MD was notified, and a voice message was left for the DON.<br><br>Record review of [Company's] Patient Care Record Summary dated [DATE], revealed, Medic three arrived on the scene to find a [AGE] year-old female sitting upright on the side of the bed with nursing home staff attempting the Heimlich maneuver. [Resident #1] was apneic (a temporary cease of breathing) and pulseless, and staff deny [Resident #1] having a DNR, so [Resident #1] was moved to the EMS stretcher and chest compressions began. [Resident #1]'s airway presents with food and vomit present. The food was removed, and the vomit was suctioned prior to beginning ventilation via BVM. An IO (process of injecting medication, fluids, or blood products directly into the bone marrow) was established in [Resident #1]'s right leg with total of three epinephrine being administered. [Resident #1] was intubated with a 7.0 ET tube (provides oxygen and inhaled gases to the lungs and protects them from contamination) placed at 21 centimeters at the teeth. Initial rhythm was asystole (heart stopped pumping) with no change. [Resident #1] was transported to [Company] Hospital for further evaluation. Upon arrival hospital, staff resumed compressions from EMS and effort were terminated via physician prior to EMS departure.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's hospital paperwork dated [DATE] and an arrival time of 08:04 PM under Chief Complaint revealed, Chief Complaint: Cardiac Arrest.72 yo female presents to the ED via EMS in cardiac arrest. EMS reports [Resident #1] is coming from a living facility and staff reports [Resident #1] was eating and began choking and went unresponsive. Arrest was witnessed by staff, and they attempted the Heimlich maneuver but were unsuccessful. On arrival EMS states [Resident #1] was unresponsive with an initial rhythm of asystole. CPR was initiated and an obstruction was noted in [Resident #1]'s airway, which was removed, and [Resident #1] was intubated. EMS gave 3 rounds of epi but only got a PEA rhythm prior to arrival. EMS states [Resident #1] had been down for ,d+[DATE] minutes.<br><br>Record review of Resident #1's hospital paperwork dated [DATE] revealed the ED Course/Rechecks as:<br><br>Progress:<br><br>8:06 PM: CPR paused for pulse check. No pulse palpated. Asystole on bedside monitor. CPR resumed.<br><br>8:06 PM: 1 of epi given<br><br>8:07 PM 1 of bicarb given<br><br>8:08 PM: CPR paused for pulse check. No pulse palpated. Asystole on bedside monitor. CPR resumed.<br><br>8:09 PM: 1 of epi given<br><br>8:10 PM: CPR paused for pulse check. No pulse palpated. Asystole on bedside monitor. CPR resumed.<br><br>8:12 PM: 1 of epi given<br><br>8:12 PM: CPR paused for pulse check. No pulse palpated. Asystole on bedside monitor. CPR resumed.<br><br>8:14 PM: CPR paused for pulse check. No pulse palpated. Asystole on bedside monitor. CPR resumed.<br><br>8:15 PM: 1 of bicarb given.<br><br>8:15 PM: 1 of epi given.<br><br>8:16 PM: CPR paused for pulse check. No pulse palpated (method of feeling with the fingers or hands during a physical examination). Asystole on bedside monitor. CPR resumed.<br><br>8:19 PM: 1 of epi given<br><br>8:20 PM: CPR paused for pulse check. No pulse palpated. Asystole on bedside monitor.<br><br>8:20 PM: Time of death called.<br><br>Interview on [DATE] at 02:44 PM with FAM A, she stated it was Resident #1's decision to be a DNR and they had discussed it at every care plan meeting. FAM A stated protocol was not followed as Resident #1's decision had not been respected.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on [DATE] at 03:32 PM with LVN A, she stated, EMS intubated Resident #1 and started CPR on her. LVN A stated, she left Resident #1's room and grabbed the paperwork from LVN B and when she returned to Resident #1's room, EMS had already started CPR. LVN A stated everything was chaotic. LVN A paused and then stated she did not tell EMS Resident #1 was a DNR because it was hectic; she just gave them the face sheet after she returned back to Resident #1's room. LVN A stated the policy was that if a resident was a DNR, they must not resuscitate them. LVN A stated normally nursing staff informed EMS if the resident was a DNR or not. LVN A stated not respecting Resident #1's code status could have made her feel not respected as her decision had no value.<br><br>Interview on [DATE] at 04:20 PM with CNA B, he stated if a resident had a DNR, they were not supposed to receive CPR. CNA B stated they could administer other life-saving measures, just not resuscitate them. CNA B stated when EMS arrived, staff must tell EMS the status of the resident to avoid them providing CPR. CNA B stated staff could find a resident's code status in their electronic file, and they also had copies of the code statuses already printed out and placed in a binder at the nurse's station and on the crash cart.<br><br>Interview on [DATE] at 11:52 PM with the ADM, he stated, EMS would be provided a copy of the resident's face sheet and be informed of the resident's code status. The ADM stated information regarding DNR's could be found in the discharge policy. The ADM stated staff should have paperwork printed to hand over with that information available when EMS arrived at the facility.<br><br>Interview on [DATE] at 12:08 PM with CNA A, she stated she was not aware Resident #1 was a DNR. CNA A stated she had not left the room as LVN A was walking by and she told LVN A she needed her because something was wrong with Resident #1. CNA A stated LVN A asked Resident #1 what was wrong, and Resident #1 just kept repeating, Help Me. CNA A stated then LVN B entered the room and asked if Resident #1 had swallowed something and then called a Code Blue. CNA A stated she left the room when the Heimlich maneuver was started and escorted the EMTs to Resident #1's room. CNA A stated she never re-entered Resident #1's room and proceeded to assist with getting other residents ready for bed. CNA A stated as she walked past Resident #1's room, she observed the EMTs putting the CPR machine on Resident #1's chest.<br><br>Interview on [DATE] at 02:34 PM with LVN B, she stated she stepped out of Resident #1's room to call 911. LVN B stated she called a code blue for more assistance. LVN B stated EMS arrived and she and CNA A escorted EMS to Resident #1's room. LVN B stated she and CNA B did not re-enter the room. LVN B stated she printed the paperwork but did not get the paperwork off the printer. LVN B stated she did not see Resident #1 when she was transported out of the facility. LVN B stated the chain of events happened so fast, she did not remember anything.<br><br>Record review of the facility policy and procedure titled, Do Not Resuscitate (DNR) ([DATE]) reflected: Facility staff will follow the resident's Advance Directives in accordance with applicable law and regulation as well as the applicable Facility Policies and Procedures. It further reflected:<br><br>2. At the time of admission and/or readmission to the Facility, Social Services or a Nursing Designee will meet with the resident and/or his/her legal representative (in the order and manner prescribed by State-specific regulations) to thoroughly review the State and the Facility protocols for advanced directives, including the resident's right to determine whether or not he/she wishes to be resuscitated in the event he/she suffers cardiac or respiratory arrest.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the facility policy and procedure titled, Discharge/Transfer (Email Revision: [DATE]) reflected:<br><br>B. Emergency:<br><br>2) Send the patient's/resident's face sheet, Advance Directives, bed-hold policy, physician orders, MAR and TAR, and any state specific records in accordance with state regulations with the patient/resident. If unable to complete the information, verbally communicate the necessary information and fax when complete.<br><br>Record review of the facility policy and procedure titled Cardiopulmonary Resuscitation, Emergency Code Blue (Revised: [DATE]) reflected:<br><br>The Facility implements policies and procedures for the provision of cardiopulmonary resuscitation (CPR) by staff, safely and according to current Basic Life Support guidance.<br><br>1. Code Blue will be announced to notify the appropriate team members to participate in a systematic, organized procedure during a potential life-threatening situation.<br><br>2. This policy only applies to residents who are full code.<br><br>3. This policy does not apply to residents who have elected DNR status.<br><br>The policy further reflected under Definitions:<br><br>5. Do Not Resuscitate (DNR) Order: Medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. Existence of an advance directive does not imply that a resident has a DNR order. The medical record should show evidence of documented discussions leading to a DNR.<br><br>The Administrator was notified of an Immediate Jeopardy (IJ) on [DATE] at 03:41 pm and given a copy of the IJ template and a Plan of Removal (POR) was requested. The facility's Plan of Removal was accepted on [DATE] at 1:25 pm and reflected:<br><br>Resident #1 no longer resides at the facility.<br><br>Residents in the facility have the potential to be affected by this alleged deficient practice.<br><br>The Director of Nursing and Administrator were reeducated by the Clinical Consultants on [DATE] on Resident Rights including<br><br>When a resident is going to be transferred out of the facility via Emergency Medical Services a verbal communication to the technicians regarding the resident's code status will occur upon Emergency Services entrance along with a copy of the Out of Hospital Do Not Resuscitate paperwork<br><br>A notebook can be found with the crash cart with Advance Directives including code status<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Licensed Nurses will be re-educated by the Director of Nursing/designee beginning [DATE] on Resident Rights including:<br><br>When a resident is going to be transferred out of the facility via Emergency Medical Services a verbal communication to the technicians regarding the resident's code status will occur upon Emergency Services entrance along with a copy of the Out of Hospital Do Not Resuscitate paperwork<br><br>A notebook can be found with the crash cart with Advance Directives including code status<br><br>This re-education will be completed by [DATE], by Director of Nursing/designee Any Licensed Nurse not receiving this education by this date will be educated prior to next scheduled shift. This information will be presented in new hire orientation.<br><br>Licensed nurses will be interviewed daily for 5 days on each shift then weekly for 2 weeks by members of nursing management to validate that the transfer of learning regarding the expectation that verbal communication to Emergency Services on a resident's requested code status will happen upon Emergency Services entrance. Interviews will begin on [DATE]<br><br>An Ad Hoc QAPI was held [DATE].<br><br>The Medical Director was notified of the Immediate Jeopardy on [DATE] and will be updated with any changes.<br><br>Verification of the POR:<br><br>-Review of the facility's Ad Hoc QAPI meeting notes, dated [DATE], reflected there was discussion of the system for resident code status and the importance of following resident's wishes at end of.<br><br>-Review of the facility's in-services revealed, the CSD conducted an in-service on [DATE] with the ADM and the DON (with signatures) regarding Resident Rights, Verbal Communication to EMS regarding Code Status and locations of the binder for Code Statuses. The details of the in-service revealed:<br><br>1) When a resident is going to be transferred out of the facility via Emergency Medical Services a verbal communication to the technicians regarding the resident's code status will occur upon Emergency Services entrance along with a copy of the Out of Hospital Do Not Resuscitate paperwork.<br><br>2) A notebook can be found with the Crash Cart and at both nursing stations with Advance Directives including code status.<br><br>-Review of an in-service conducted on [DATE] by the DON titled, Advanced Directives DNR/Full Code Status and Giving Report to EMS, reflected staff (with signatures) had been educated on the facility's Resident Code Status Order Policy and the following:<br><br>1) Check for resident code status<br><br>2) When resident transferred out give verbal report to EMS of being full code or DNR<br><br>3) Have OOHDNR ready once EMS is called to transfer the resident<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 4) If the resident is DNR ensure that the paperwork is sent out with the resident<br><br>5) There will be a notebook at the nurses' station with Advanced Directives including code status<br><br>Observation on [DATE] at 01:35 PM revealed the Advanced Directives binders were at the two nurses' station and on the crash cart.<br><br>On [DATE] interviews with multiple staff members across various departments and shifts revealed the staff members were recently in-serviced properly on DNR Election Form Policy and Procedure. Each staff member was aware of the steps of completion of the DNR Election Form. No concerns were noted from these interviews.<br><br>Interview on [DATE] at 01:40 PM with the ASW, she stated the SW left the Advanced Directives in a folder and she filed them. The ASW stated she assisted with scanning the forms as needed. The ASW stated family and/or the resident chose the DNR status. The ASW stated after the decision was made, it stood. The ASW stated the SW advised nursing staff and management, and a copy was left at the nursing station and also uploaded into the residents' EMARs.<br><br>Interview on [DATE] at 01:51 PM with the CM, she stated she met with new residents and completed the assessments checklist. The CM stated she confirmed the residents code status at this time. The CM stated if the resident was already a DNR, she verified it with the family and the doctor to make sure there was an order for a DNR. The CM stated she made copies and placed the copies in the binders (5 copies for easy retrieval if a resident was sent out) at the nursing station. The CM stated she uploaded a copy into the EMAR under the documentation tab and made sure the face sheet was updated with the DNR status. The CM stated as a nurse, she notified EMS when they entered the facility and gave them a quick assessment. The CM stated she or someone else had printed the transfer paperwork and given it to the EMTs. The CM stated she was in-serviced on Monday ([DATE]) by the Education Staff Development (ESD) on DNR's, where they were kept, and properly notifying the EMTs if the resident was DNR or full-code. The CM stated today, Tuesday ([DATE]) the DON completed an in-service with her on where the DNR binder was located. The CM stated the binders were located at the nursing stations and also on the crash cart.<br><br>Interview on [DATE] at 02:05 PM with LVN C, she stated prior to EMS arriving, she would have already checked a resident's code status. LVN C stated when EMS arrived, she would inform the status immediately and hand them the paperwork. LVN C stated she would remain with her resident and had a different nurse print the paperwork so she could stay with EMS from the beginning to the end. LVN C stated that way she would be in the room if EMS attempted CPR and the resident was a DNR. LVN C stated she was in-serviced on remaining with the resident. LVN C stated nursing staff should know where the code status binder was located. LVN C stated the binder was located at the nursing station. LVN C stated they had two binders (one for the DNR status and the other binder had all residents with DNR and full code). LVN C stated the binder for all residents was on the crash cart and it was updated every night. LVN C stated she learned to prepare herself as a nurse in any type of situation. LVN C stated staff should act fast when things happened and complete the total assessment. LVN C stated paperwork should be ready prior to EMS' arrival. LVN C stated if staff needed help from a co-worker, call for assistance immediately so they could help with paperwork, etc. LVN C stated the code status should had been checked and provided to EMS upon their arrival. LVN C stated in addition to Resident #1 expiring, she could had received broken bones of her ribs, bruising, dislocations, and hematomas (pool of mostly clotted blood that forms in an organ, tissue, or body space).<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on [DATE] at 02:20 PM with the ADON, she stated she arrived to work last night at 9:45 PM and educated the night nurses and interviewed them. The ADON stated she educated staff on what to do if a resident was going to the hospital or any emergency. The ADON stated she instructed the night nurses to check the code status first and upon entrance EMS was to be provided a verbal report as well as paperwork if they are transferring the resident out. The ADON stated they also discussed where to locate the Code Status/Advance Directive binders which were kept at each nursing station and on the crash cart. The ADON stated no one had any questions. The ADON stated management would discuss any changes to the binders during the morning meetings and the binders would be updated accordingly. The ADON stated she learned how important it was for EMS to have the printed directive in their hand and to receive a verbal confirmation. The ADON stated her expectations were for the nursing staff to follow directions and protocols. The ADON stated if staff had any questions to not hold off, especially if it needs to be addressed immediately. The ADON stated the nurses should had double-checked the status code and not panicked.<br><br>Interview on [DATE] at 02:34 PM with LVN B, she stated she had been in-serviced several times on Monday ([DATE]) by the ADON on what to do when EMS was called. LVN B stated they were to verbally inform EMS of the code status, provide a printout of the code status, the face sheet, and the medication sheet. LVN B stated she was also in-serviced today ([DATE]) by the DON on the same material regarding the code status, verbal status, to print directives, the face sheet, and the medication list. LVN B stated the DON also quizzed her about where to locate the code status. LVN B stated if a resident was a DNR, staff must ensure the resident's paperwork was printed and sent out with the resident. LVN B stated also, she was quizzed on where to locate the advanced directives (electronic and paper form). LVN B stated the DON made sure she knew where to locate all the information. LVN B stated she did not learn anything new; it was more of a refresher.<br><br>Interview on [DATE] at 02:47 PM with the CSD, she stated she re-educated the ADM, the DON, and all licensed nurses on when a resident was going to be transferred by EMS, they must provide a verbal report and a printed copy of the code status when EMTs entered the building and a printed copy of the OOH DNR. The CSD stated she interviewed the nursing staff and ensured the information was understood. The CSD stated the nursing staff would also be quizzed for 5 days on the in-service to ensure the information was retained. The CSD stated on [DATE], they had an Ad Hoc QAPI meeting via phone with one of their MDs. The CSD stated the Advanced Directive binders were located on the crash cart and at each nursing station. The CSD stated they had not made any changes to their policy. The CSD stated during morning meetings, they discussed any changes and updated the binders throughout the day. The CSD stated her expectation was for the staff to inform the EMTs of the resident's name, code status and give an assessment of the situation.<br><br>(continued on next page) |

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| The Pavilion at Creekwood | 2100 Cannon Dr<br>Mansfield, TX 76063 |

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) |
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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on [DATE] at 03:00 PM with the DON, she stated she started education yesterday ([DATE]) with the nursing staff on checking code status and giving verbal reports to EMS. The DON stated the ADON came to the facility last night ([DATE]) at 10:00 PM to continue in-servicing the night staff. The DON stated she arrived at the facility at 5:00 AM ([DATE]) to complete in-services with the morning crew. The DON stated they were in-servicing and conducting questionnaires for 5 days on EMS, code status, and proper paperwork. The DON stated she wanted the facility to start conducting code drills monthly, currently they do annual competencies and the next one is in [DATE]. The DON stated for now they would start conducting code drills monthly and monitor. The DON stated she just wanted everyone to not panic. The DON stated staff should never leave EMS alone in the room. The DON stated even though staff provided EMS paperwork, staff should verbally give EMS a report to include the reason staff called, the baseline, vital signs, labs, and have the fracture information ready in case the resident must go into surgery. The DON stated staff must be as accurate as possible.<br><br>Interview on [DATE] at 03:16 PM with the ADM, he stated they completed in-services with the nursing staff on where to find the code status and how to present the information to EMS. The ADM stated the information should be given verbally and a printout should also be provided to EMS. The ADM stated the binder with the advanced directives were located on the crash cart and at each nursing station to remain readily available to provide a printed copy to EMS. The ADM stated the nursing staff would be quizzed daily for 5 days, then once a week for 2 weeks, etc. The ADM stated they would not allow any nurse to start their shift until they were in-serviced. The ADM stated whenever EMS entered the facility, they would be handed a printout and the information would be verbally communicated. The ADM stated an Ad Hoc QAPI meeting was held with the MD on [DATE]. The ADM stated the policy said to hand EMS the information, and they would be changing it to say do both (verbally and printed).<br><br>The Administrator was notified the IJ was removed on [DATE] at 1:25 PM, however the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. |