STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676481	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Senior Living	118 Trinity Shores Drive Port Lavaca, TX 77979

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** 26869 Based on interview and record reviews, the facility failed to comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). The facility was not relieved of its obligation to provide this information to the individual once he or she was able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time for 1 of 1 (Resident #1) reviewed for Advanced Directives, in that: Resident #1's RP wished to have a DNR code status for Resident #1. Resident #1's OOHDNR was not valid, and Resident #1 was administered CPR by LVN A and RN B on [DATE]. This deficient practice could affect residents with an OOH-DNR and could result in residents not getting their Do Not Resuscitate wishes honored. The noncompliance was identified as PNC. The IJ (Immediate Jeopardy) began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. The findings included: Record review of Resident #1's Admission Record, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses that included: ESRD (end stage renal disease, pulmonary edema, diabetes II (a chronic (long-lasting) health condition that affects how your body turns food into energy.), altered mental status, anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen) in chronic kidney disease, vascular dialysis catheter, peripheral vascular disease (a slow and progressive disorder of the blood vessels. Narrowing, blockage, or spasms in a blood vessel can cause PVD), acquired absence of right leg below the knee, dependence on renal dialysis, cognitive communication deficit disorder of brain. Further review revealed the resident expired on [DATE]. Record review of Resident #1's electronic chart revealed in red lettering (on the banner of the resident electronic chart on top)- DNR. Record review of Resident #1's consolidated physician orders for [DATE] revealed an order for a code status of DNR order date was [DATE]. (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	Record review of Resident #1's OOHDNR, dated [DATE], revealed the document had no physician signature in the electronic chart. Record review of Resident #1's telephone order, dated [DATE], revealed an order for the resident's code status to be change to DNR was created by ADON/RN N. Further review revealed this order for DNR was not signed by the physician until [DATE]. Record review of Resident #1's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 2, which indicated the resident was severely cognitively impaired. Further review revealed MDS section I Active Diagnoses indicated the resident had diagnoses of: PVD (peripheral vascular disease), renal insufficiency renal failure, or end stage renal disease (ESRD), Diabetes, Alzheimer's disease, cerebrovascular accident (CVA)/transient ischemic attack (TIA) or stroke, non-Alzheimer's Dementia, asthma, and anemia in chronic kidney disease. Record review of Resident #1's care plan, dated [DATE], revealed the resident's care plan indicate a code status of DNR (dated [DATE]). Further review revealed interventions for the resident's DNR code status was: do not perform CPR, should resident be found without pulse, respiration. Record review of Resident #1 progress notes, dated [DATE], revealed it was documented Resident #1 was pronounced dead on [DATE] at 4:43 AM by EMS. Record review of Resident #1 progress note dated [DATE] at 5:30 PM by LVN A, revealed LVN A documented on [DATE] at approximately at 3:58 AM RN B came down the hall and asked if Resident #1 was a full code or DNR. LVN A looked it up on the computer and thought LVN A saw that Resident #1 was a full code. At that time, facility staff started CPR and LVN A came back the desk to call 911. EMS arrived approximately 10 minutes later and took ever CPR. LVN A stayed with Resident #1 to help and provide information as needed. Approximately 15 minutes later, RN N came to the room and stated Resident #1 was a DNR not a full code. By that time CPR had been in progress for approximately 30 minutes. So, EMS continued the CPR also the OOHDNR form EMS requested was not signed by a DR. So, they (EMS) continued the code until they called the local emergency room and spoke to the DR who called the code and time of death at 4:43 AM. LVN A then contacted [Resident #2's family member] and explained to them the Resident #1 had passed away. Resident #1's family member arrived at the facility soon afterwards. During an interview with LVN A on [DATE] at 4:55 PM, LVN A stated he was the night nurse who cared for Resident #1 on [DATE]. LVN A stated the last time he saw Resident #1 earlier that night Resident #1 had vomited (Mexican food brought in by the resident's family member), nurse cleaned Resident #1 up and changed the resident's clothes. LVN A stated Resident #1 seemed to be quiet and brought the resident his pain medications. LVN A stated the Resident #1's family member had brought the resident food that night and maybe it did not set well in his stomach. LVN A stated Resident #1 was normal for him not to eat too much. LVN A stated Resident #1 was in and out of the hospital and left home and then came back to the facility. LVN A stated Resident #1 was readmitted from home because the resident's family member could not care for him. LVN A stated he did CPR which entailed compressions, called 911, and EMS, and further stated when EMS had placed the AED pads-did not advise to shock the resident and continued to be unresponsive. LVN A stated RN B, who was working as a CNA that night, found Resident #1 and came to get him. LVN A stated Resident #1 was found unresponsive with no pulse, and when he looked at the resident's chart and he thought the resident was a full code. (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 with RN B on [DATE] at 9:21 AM, RN B stated she worked as needed and was working in a CNA slot that night. RN B stated Resident #1's family member had brought Mexican food in and Resident #1 had vomited once that night. RN B stated the resident's vitals were normal and had been cleaned by her and LVN A around 11:30 PM. RN B stated Resident #1 had behaviors of yelling out for help and when staff went to check on him, the resident had forgotten what he needed. RN B stated she would check on Resident #1 every 30 minutes. RN B stated LVN A administered Resident #1 pain medications around 11:30 PM. RN B stated she found Resident #1 unresponsive about 3:55 AM and notified LVN A. RN B stated Resident #1 had no pulse, and he had not fallen. RN B stated LVN A checked the computer for Resident #1's code status, and replied the resident was a full code, so they got the crash cart, vital machine, compressions, and 911 was contacted. RN B stated they had started CPR compressions, then EMS arrived and took over- maybe around ,d+[DATE] AM. RN B stated another nurse brought Resident #1's OOHDNR form, and EMS stated it was not valid since the physician signature was missing. EMS preceded to do CPR on Resident #1, then she left the room. RN B stated LVN A was still in Resident #1's room with EMS. During an interview Resident #1's family member on [DATE] at 11:00 AM, Resident #1's family member stated she had signed the OOHDNR due to Resident #1 being in poor health and was too weak. During an interview with the Admission/Marketer on [DATE] at 11:50 AM, the Admission/Marketer stated Resident #1's family member had requested Resident #1 to have an OOHDNR form due the hospital physician stated Resident #1 was in poor health. The Admission/Marketer stated she let Resident #1 family member know the OOHDNR had to be completed before the resident was considered a DNR. The Admission/Marketer stated she gave the OOHDNR, that had two witnesses' signatures, and then gave the OOHDNR to one of the ADON/RN/Medical Records D. The Admission/Marketer stated she uploaded Resident #1's OOHDNR and in parentheses added OFS (out for signature). During an interview with ADON/RN/Medical Records D on [DATE] at 12:08 PM, ADON/RN/Medical Records D stated when the Admission/Marketer gave her a OOHDNR she would take it to the physician's office to have the physician sign the OOHDNR for residents and then would upload the OOHDNR form in the resident record. ADON/RN/Medical Records D stated she would notify the ADM, DON, and charge nurse of the OOHDNR was completed and in the resident's chart. ADON/RN/Medical Records D stated she did not remember receiving Resident #1's OOHDNR form or uploading it to the resident's chart in the computer. ADON/RN/Medical Records D stated, in Resident #1's chart, under Advanced Directive and initial OFS, ADON/RN/Medical Records D stated she was not sure what OFS initial meant. During an interview with the DON on [DATE] at 1:45 PM, the DON stated the staff had notified her of Resident #1's death and she had come to the facility. The DON stated nursing staff was responsible in making sure all residents had the correct code status in their charts. The DON stated Resident #1 did not have an OOHDNR form completed, so the resident would remain full code. The Administrator and DON were notified on [DATE] at 10:23 PM, that a past non-compliance IJ situation had been identified due to the above failures. The facility course of action prior to entrance included: PNC IJ verification: F578 (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 with ADON/LVN C on at [DATE] at 5:33 PM, ADON/ LVN C stated she did the staff training with nursing staff on OODNR/CPR/change of conditions on [DATE]. Record review revealed 84 of 84 direct care staff were in serviced on [DATE] Code Status/change of condition with ADON/RN/Medical Records D and ADON C. Nurses, CNA, MA where to find the location of the code status. Non-clinical staff refer to charge nurse for assistance with code status, If you do not have access to matrix. If at any time these do not match you must notify the ADON, DON and Administrator immediately. Interviews with nursing staff revealed they had received trainings for OOHDNR forms, resident code status location, and chance of condition - nursing staff were able to state what trained on: During an interview with the Administrator on [DATE] at 7:17 PM, the Administrator stated she was trained on where to locate a resident's code status on [the electronic medical records system] (face sheet, order, care plan, OOHDNR). The Administrator stated if the code status's does not match, then let the charge nurse know. During an interview with RN D on [DATE] at 7:58 PM, RN D stated she worked here for about one month and had worked here in the past. RN D stated she was trained on where they could find the code status for residents in different locations in chart, could find in orders, could find in the POC for aides, make sure the OODNR was completed. RN D stated staff were to notify the Administrator, DON, or ADON if a resident's code status did not match. During an interview with CNA E on [DATE] at 8:01 PM with CNA E had worked here for 1 year. Yes, she was trained was on residents POC [the electronic medical records system] (residents care plan on the POC). CNA E stated she would notify the charge nurse if change in resident. During an interview with on [DATE] at 8:08 PM with ADON/ LVN F worked here for 7 months. Yes, she was trained was about advanced directives, where to find the code status for residents [the electronic medical records system] and how to access it. If the code status does not match, she would look for the OODNR in documents. The OODNR was valid with Resident/RP signature, 2 witnesses' signatures and physician signature. If missing a signature, it would not be valid. Notify Admin, DON, ADON if do not match. During an interview with on [DATE] at 8:15 PM with MA G had worked here for 4 yrs. Yes, she was trained on code status, [the electronic medical records system] (resident on banner at top of chart, face sheet) Also, trained on notifying charge nurse if the code status does not match. During an interview with on [DATE] at 8:18 PM with CNA H worked here for 2 weeks. Yes, she was trained on OODNR. CNA H sated she would check the residents POC [the electronic medical records system] for the code status. Also, CNA H would ask nurse about a resident code status. CNA H would notify the charge nurse for change in resident condition. (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 with on [DATE] at 8:25 PM with ADON/LVN I had worked here for 5 months. Yes, she was trained on where to find code status [the electronic medical records system]. ADON/LVN I was trained on where to find who initiated the code status in residents' chart. For OODNR's when admitting she would view the OODNR form to make sure all signatures were completed. ADON/LVN I stated until the OODNR was completed, staff should not create the order. If the code status does not match look at OODNR form and verify its valid. If not validated she would let the floor manager know and correct the code status with DON/ADON and Resident/family. If OODNR form not valid then resident was still considered a full code. During an interview on [DATE] at 8:31 PM with LVN J had been working here for 2 years. Yes, she was trained on advanced directives and mock CPR. This entailed staff check resident code status, [the electronic medical records system] staff brought crash cart, who would call 911, and ADON's monitored. LVN J stated she was trained on advanced directives where to find in the resident chart, the definition, how the OODNR form needs to be filled out completely and where to go to access it. If transferring print out the OODNR form, so it will go with resident. If code status does not match in the resident chart, you have to perform CPR if resident was not responsive. LVN J stated she would notify the ADM, DON, ADON if the resident code status did not match and change of resident condition. During an interview on [DATE] at 8:36 PM with LVN K stated she had worked here for 3.5 yrs. Yes, she was trained on computer. LVN K stated she was trained on where to find the code status, [the electronic medical records system] (on top banner of resident chart, face sheet, and in documents-advanced directive). Also, trained on where to find crash cart and mock CPR. If the OODNR form had to have all signatures to be competed. If the OODNR form was not completed the resident remained full code. If code status does not match, LVN K would double check the OODNR. Resident remains full code until DNR status was completed/valid. LVN K she was trained on who to notify for resident change of conditions. During an interview on [DATE] at 8:48 PM with CNA L had worked here for 4 yrs. Yes, she was trained on where to find code status on residents POC [the electronic medical records system]. CNA L stated she was trained on who can do CPR or not. CNA L stated she was trained to talk to nurse about any change in the resident. During an interview on [DATE] at 8:51 PM with CNA M had worked here for 1.5 yrs. Yes, she was trained on resident code status where to find on POC [the electronic medical records system]. CNA M stated if resident was a DNR, it would be in red and had resident picture. If she sees something wrong with resident, she alerts a nurse. If resident had a change of condition, she would get the nurse. During an interview on [DATE] on 9 AM DON had worked here for 2 weeks. Yes, she was trained on code status, where to find it. The DON stated she could find the resident code status on [the electronic medical records system] (top of banner in resident chart, face sheet, order, OODNR). If the residents code status did not match and when she would follow the OODNR form. The DON stated, if the OODNR form was missing signatures the resident was a full code. The DON stated she was trained on change of condition of a resident- she would complete the SBAR and prompt nurse. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled, Emergency Procedure- Cardiopulmonary Resuscitation, dated , d+[DATE], revealed, 6. If an individual is found unresponsive and not breathing normally, a license staff member who is certified in CPR/BLS shall initiate CPR unless: a. is known that a DNR order that specifically prohibits CPR and/or external defibration exist for that individual: 7. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a valid OOHDNR. The noncompliance was identified as PNC. The IJ began on [DATE] and corrected on [DATE]. The facility had corrected the noncompliance before the survey began on [DATE].