

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/02/2015
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NAME OF PROVIDER OR SUPPLIER THE NEIGHBORHOODS AT BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 YORKSHIRE DR BROOKINGS, SD 57006
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F 000	INITIAL COMMENTS Surveyor: 32332 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/1/15 through 9/2/15. Areas surveyed included quality of care and treatment, resident safety, and resident assessment with a death. The Neighborhoods at Brookview was found not in compliance with the following requirements: F155 and F281.	F 000	F155 1. All residents have the right to make and communicate decisions in regards to their code status. 2. All residents are at risk.	10-16-2015
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by:	F 155	3. The Director of Nursing will in-service all staff, including RNs A, B & C, on resident rights and following their code status wishes. The Interdisciplinary team will be monitoring for changes in conditions that may require further discussion in regards to code status and the need to potentially change their code status. If any full code resident has a change in status, the Nursing Supervisor/designee will follow up with resident/family and/or physician about code status. In the event the family is reluctant to address the code status with the resident, the physician will step in to discuss the code status with the resident and/or family if needed.	10-7-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator

10-7-15
9-20-15

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.

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F 155	<p>Continued From page 1</p> <p>Surveyor: 32332</p> <p>Based on record review, interview, and policy review, the provider failed to ensure resident wishes had been followed for one of one sampled resident (3) who had died with full code (resuscitation) orders and did not receive emergency cardiopulmonary resuscitation. Findings include:</p> <p>1. Review of resident 3's medical record revealed: *He had been admitted on 2/5/15. *The 2/5/15 transfer form from another provider indicated "Code status: Full Code." *A 9/3/14 healthcare power of attorney form signed by resident 3 listing two sons as appointed powers of attorney "to consent to, reject, or to withdraw consent for medical procedures, treatment, or intervention." *A 9/3/14 living will declaration signed by the resident indicated "With respect to life-sustaining treatment, I direct the following:" -A check mark had been marked by the sentence, "If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain." -A check mark had been marked by the sentence, "I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent or I become permanently unconscious." -No further instructions had been listed below the above statement. *His last reviewed 2/23/15 care plan had listed additional problems/interventions: "Yes Code Status." *A page at the front of the paper chart contained</p>	F 155	<p style="text-align: right;"><i>10-7-15 AM</i></p> <p>4. The Director of Nursing/designee will complete audits weekly x 4 and monthly x 3 to insure that staff have provided education to those alert residents that are full codes and are declining. The Director of Nursing/designee will complete audits weekly x 4 and monthly x 3 to insure that resident wishes are reflective of what is documented in the resident's chart/EMR. Results of the audits will be reported by the DNS and discussed at the monthly Quality Assessment and Assurance for further review and recommendations and/or continuation/discontinuation of audit.</p>		

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F 155	<p>Continued From page 2 an adhesive sticker indicating "YES CODE."</p> <p>Review of RN A documentation in Care Coordinator Notes regarding resident 3: *On 7/26/15 at 8:00 p.m. she had given the resident his medication; he had eaten a protein bar at that time. -At 9:00 p.m. she had performed a dressing change on him, and he had participated with repositioning. *On 7/27/15 between 3:30 a.m. and 4:00 a.m. staff had checked on him and changed his brief. He had voided into a urinal during his scheduled rounds. *On 7/27/15 at 5:00 a.m. he was found sitting on the floor next to his bed.</p> <p>RN A's assessment notes on 7/27/15 at 5:00 a.m. regarding resident 3 revealed: *His pulse was absent. *His skin was cool to the touch and very pale/white in color with purple lips. *He was limp and unresponsive. *His pupils were fixed and nonresponsive. *There was no audible heart beat heard when listening through a stethoscope (a device with earpieces used to amplify noise) for one minute. *There was no obvious injury such as bruising, lacerations (cuts), or bumps. *Staff had lifted him onto his bed. *She contacted the immediate supervisor case manager (RN B) who had directed her to contact the director of nursing (DON). *She contacted the DON who had directed her to contact the emergency department (ED) at the provider's hospital with information. *She called the ED and informed the nursing supervisor at the ED that the "resident is a full code and was found sitting on the floor with no</p>	F 155			

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F 155	<p>Continued From page 3</p> <p>pulse and no breath sounds noted and that the DON inform writer not to use the standing order for a release of body." *She received an order for the release of the body from the ED supervisor after the supervisor had contacted the on-call physician for that order. *The ED supervisor called back and informed staff the police needed to be notified due to the "unexpected death." *Police arrived at 6:00 a.m. *Ambulance personal arrived at 6:05 a.m. to check for signs of life. *After the police were contacted five family members were contacted with information on the resident's status.</p> <p>Interview on 9/1/15 at 10:55 a.m. with household coordinator E revealed: *When asked how she would know if a resident had orders for full code resuscitation she would either: -Look for resuscitation orders in the medical record on the computer. 'Full code' meant the staff were to have attempted to resuscitate the resident. -Look in the resident's care plan. If the care plan had indicated 'Yes Code status', it had meant the staff were to have attempted to resuscitate the resident. -Look on the face of the chart for a green dot that indicated staff were to resuscitate them.</p> <p>Interview on 9/1/15 at 3:05 p.m. with the director of nursing (DON) regarding the events on 7/26/15 and 7/27/15 with resident 3 revealed: *She was aware resident 3 had orders for full code resuscitation. *She and other facility staff had visited with the resident's medical power of attorney (POA) and</p>	F 155			

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F 155	<p>Continued From page 4</p> <p>other family members on 6/30/15, 7/1/15, 7/2/15, 7/6/15, and 7/16/15 regarding his overall physical and mental declines.</p> <p>*They had encouraged the family to change his code status from "full code" to "do not resuscitate".</p> <p>*The physician's assistant had also visited with the family about changing the code status.</p> <p>-She was unable to locate documentation of that visit in the medical record.</p> <p>*The family had thought the resident had already changed the code status to DNR prior to being admitted to the provider's facility.</p> <p>*The POA had agreed the code status should have changed but wanted to visit with other family members and with the resident before making the change.</p> <p>*The POA or other family members had not visited with him about changing the status before he expired.</p> <p>Interview on 9/1/15 at 4:00 p.m. with RN A regarding the above events of 7/26/15 and 7/27/15 revealed:</p> <p>*During her medication pass and dressing change with resident 3 there were no signs of a change in condition.</p> <p>*He had exhibited some confusion for a few days prior to the event, but he had responded to her as she was caring for him.</p> <p>*She had last seen resident 3 around 10:30 p.m. The certified nursing assistants (CNA) had done resident rounds every two hours.</p> <p>*CNA D had called for help between 4:30 a.m. and 5:00 a.m.</p> <p>*She had entered resident 3's room and found him sitting on the floor.</p> <p>*She reached to remove his C-PAP (continuous positive airway pressure) (used to assist with</p>	F 155			

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F 155	<p>Continued From page 5</p> <p>breathing) mask and could see that he had expired.</p> <p>*She wanted him placed on the bed. so she called for other nurses in the building for assistance.</p> <p>*She could not find a pulse, heartbeat, or blood pressure. The pupils of his eyes were fixed and dilated (enlarged).</p> <p>*He was "not cold but not warm like he had been earlier."</p> <p>*She was unable to lift so she left the room to assist another resident while the CNAs and nurse lifted him onto the bed.</p> <p>**I was in shock because it was totally unexpected."</p> <p>*She had not known he had orders for full code resuscitation, but RN C knew he was full code and had told her.</p> <p>*She asked RN C if she should gather CPR/AED equipment, and she told her "no, that he was already gone."</p> <p>**So then I called [the nursing supervisor] [RN B)], who told me to call [the DON], and she said to call the ER [hospital emergency department]."</p> <p>*None of the above had instructed her to begin resuscitating the resident.</p> <p>*Although he had exhibited physical and mental declines for the past few weeks she did not believe his death was imminent (about to occur at any moment), because it had been unexpected to her.</p> <p>*When asked why she had not started CPR she stated, "He was white. He was gone."</p> <p>*She had not seen any rigor mortis (stiffness of the joints after death), or mottling (pooling of blood causing purple/black discoloration).</p> <p>Interview on 9/1/15 at 4:20 p.m. in a phone call with resident 3's physician and the provider's</p>	F 155		

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F 155	<p>Continued From page 6</p> <p>medical director revealed: *He had not been surprised by resident 3's death due to gradual overall declines. *He believed the resident probably had a heart attack. *He stated the nursing staff responded appropriately by not starting resuscitation attempts. *It was "quite apparent he needed to be DNR [do not resuscitate], but that [obtaining the DNR orders] had not been accomplished." *The resident did not have the mental capacity to make the decision regarding his resuscitation. *The physician's "opinion is CPR doesn't work for this age group." *"I know there are a certain set of rule to abide by, but we need common sense as well."</p> <p>Interview on 9/1/15 at 5:30 p.m. with CNA D revealed: *He had been working the night resident 3 had expired. *He had assisted with the resident's care at least every one and one-half to two hours. *The resident called often for a urinal. *He had found the resident on the floor, checked for a pulse, and called for help. *No one had attempted to start CPR. *"The nurse had said he was cool so nothing could be done." *No one called 911 until they called the emergency room and were instructed to get the police involved.</p> <p>Interview on 9/2/15 at 8:20 a.m. with nursing supervisor B revealed: *She was the nursing supervisor in charge of resident 3. *She had not been working the night of 7/26/15 -</p>	F 155			

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F 155	<p>Continued From page 7 7/27/15.</p> <ul style="list-style-type: none"> *There were no nurses on-call for emergencies. *RN A had called her to tell her what had happened to resident 3. *She had told RN A to call the DON. *She was aware that resident 3 had orders for a full code resuscitation. *She had been involved with the DON during visits with the POA regarding getting his code status changed. *She had never visited with resident 3 about his wishes regarding his resuscitation status, because the family wanted to talk to him about it. *Resident 3 had some episodes of confusion but would have been able to verbalize his resuscitation wishes to his son. *When RN A called her on 7/27/15 she (nursing supervisor B) had not told RN A resident 3 was a full code resuscitation. *She had assumed RN A had known he had full code orders. *When asked about full code resuscitation she stated, "If a resident is cool, I am not going to start CPR in a nursing home. You can do so much damage with CPR." *When asked if she felt resident 3's death was imminent she stated he had a bad heart and could have had a heart attack at any time. <p>Interview on 9/2/15 at 8:40 a.m. with RN C revealed:</p> <ul style="list-style-type: none"> *She had been working on another neighborhood unit on the night of 7/26/15 - 7/27/15. *She had received a call about 5:00 a.m. from one of the CNAs to "come right away to [neighborhood room #] because someone was on the floor." *"They didn't tell me he was unresponsive or anything." 	F 155			

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F 155	<p>Continued From page 8</p> <p>*She had been drawing blood from another resident, so she finished what she was doing, cleansed her hands, and put things away. It had taken her approximately five minutes to finish her work.</p> <p>*The resident was on the floor when she entered the room, and they lifted him onto the bed.</p> <p>*RN C had not been told the resident had expired.</p> <p>*She had not known he had orders for a full code resuscitation.</p> <p>*She proceeded to clean the resident.</p> <p>*RN A had not been in the resident's room. She had been making phone calls in the nursing area.</p> <p>*When RN A came into the resident's room she told RN C he was a full code status.</p> <p>*RN C stated she had already been in the room fifteen minutes before she had been told of the status.</p> <p>***"I told her he was already gone."</p> <p>***"I called the ED and told them to call an ambulance. The ambulance was already on the way."</p> <p>*There was no rigor mortis.</p> <p>*There was some mottling, "More like a pink flushed color on his cheeks, face, and hands. He was always flushed. His legs had a purple color. But he had very bad circulation."</p> <p>*She stated if she were his nurse and had known he had full code resuscitation orders she would not have initiated CPR, because he was cold and had some mottling.</p> <p>Interview on 9/2/15 at 9:30 a.m. with the DON revealed:</p> <p>*She believed her nurses had followed the provider's policy for resuscitation/code blue, because the policy stated that at times it was necessary to deviate from the procedure based</p>	F 155		

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F 155	<p>Continued From page 9</p> <p>on the status of the patient (resident) and judgment of the nursing staff regarding a resident's status.</p> <p>*She agreed emergency services had not been contacted appropriately for a full code resident with an absent pulse, heartbeat, and breathing.</p> <p>*She had not instructed RN A to begin resuscitation efforts when she had called on 7/27/15.</p> <p>*She had not visited with resident 3 regarding his wishes for resuscitation, because the family wanted to visit with him.</p> <p>*A BIMS (brief interview for mental status) test had not been conducted for resident 3 since 5/20/15, when the score had been 14 (indicating his mental status was intact at that time).</p> <p>*He had exhibited recent periods of confusion.</p> <p>*She was aware of the American Heart Association's guidelines for when resuscitation should not occur, but they were only guidelines, and the provider's policy had allowed room for deviation.</p> <p>*She understood the resident's wishes had not been followed according to the living will declaration he had signed.</p> <p>*There was a very fine line for nursing to make decisions on behalf of the resident.</p> <p>Review of the provider's August 2013 Code Blue policy revealed:</p> <p>*Patient care policies and procedures were written to guide staff in providing direct care.</p> <p>*At times it was necessary for staff to deviate from the established procedure.</p> <p>*Deviation would be based on the clinical needs/status of the patient, and the judgement of the staff determined to be in the best interest of the patient.</p> <p>*A staff member would initiate the code using the</p>	F 155			

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F 155	<p>Continued From page 10</p> <p>overhead paging system announcing "code blue" followed by the location of the room.</p> <p>*Nursing staff would gather supplies (back board, oxygen, AED), dial 911, and notify the family and physician.</p> <p>*CPR and AED use would continue per American Heart Association guidelines until care was taken over by the ambulance staff.</p> <p>Review of Laurie J. Morrison et al, Part 3: Ethics: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, WWW. http://circ.ahajournals.org/content/122/18_suppl_3/S665.full.pdf+html, accessed on 9/3/15 revealed:</p> <p>Criteria for Not Starting CPR in all OHCA (out-of-hospital cardiac arrest:</p> <p>***While the general rule is to provide emergency treatment to a victim of cardiac arrest, there are a few exceptions where withholding CPR might be appropriate as follows:</p> <ul style="list-style-type: none"> -Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril. -Obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition). -A valid signed, and dated advance directive indicating that resuscitation is not desired, or a valid, signed, and dated DNAR order." <p>Review of the provider's May 2000 policy for Do Not Resuscitate (DNR) revealed:</p> <p>***The competent person should be encouraged to discuss his or her desires in regards to the resuscitation or life-sustaining measures with his/her personal physician and family members."</p> <p>*The person's decision would be respected above</p> 	F 155			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/02/2015
NAME OF PROVIDER OR SUPPLIER THE NEIGHBORHOODS AT BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 2421 YORKSHIRE DR BROOKINGS, SD 57006		
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F 155	Continued From page 11 the desires of the family or anyone else unless this decision was deemed to be irrational or otherwise in violation of policies. *If there was family disagreement as to the person's decision on no code status, this was to have been brought to the attention of administration and the Ethics Committee as appropriate. **"An incompetent person should be involved in the decision making process in regards to his or her care and treatment to the extent of his capacity. ***If the incompetent person has previously, while being competent, presented an appropriate advance directive containing his or her wishes regarding life-sustaining measures, then those wishes should be respected unless deemed inappropriate, irrational, or otherwise in violation of policy or state law." *If no family members are available, after reasonable efforts are made to identify and contact such members, and the attending physician thinks that there may be potential question regarding prognosis of the person, the Ethics Committee may be asked to review the case and express its opinions regarding life-sustaining measures. ***If an appropriate personal representative is in a position to make a decision for the incompetent person, or if there is a disagreement among other family members, the matter will be reported to the nursing home administrator and, if appropriate, the Ethics Committee may be convened." **"Do not resuscitate" requires a physician's order." **2 c. The physician's progress notes in writing or dictation will reflect evidence that the physician had discussed the decision with the patient and that they have mutually reached a decision."	F 155			

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F 155	Continued From page 12 <p>"3. If the patient is judged by the physician not to have the capacity to make decisions, that fact should be documented along with other evidence supporting the decision not to resuscitate"</p> <p>"In cases where cardiopulmonary resuscitation would be clearly futile [a treatment is clearly futile...if it will not achieve it's physiologic objective and so offers no physiologic benefit to the patient.]" the physician may issue a DNR order without item 2 c or 3 above. Reasonable efforts should be made to inform the patient or surrogate of this decision. The physician should document "clear futility" in the medical record."</p> <p>Review of the provider's undated Resident Handbook revealed: *Page 13: The resident's rights were valued and respected by all our staff. *Page 19: Resident Bill of Rights: Every resident of the (provider) had the right to: -2. Know the facility's policies regarding living will, advance directives, durable power of attorney, record access, and privacy practices. The resident had the right to formulate and communicate wishes regarding health care decisions as it related to any of those issues and to expect they would be recognized. -7. Be fully informed in advance about care and treatment, and of any changes in that care or treatment that may affect the resident's well being. -8. Participate in planning care and treatment.</p>	F 155			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to ensure two of two licensed nurses (A and C) followed the facility policies for one of one sampled resident (3) identified as a full code (resuscitation) when discovered without a pulse, heartbeat, and not breathing. Findings include:</p> <ol style="list-style-type: none"> Review of resident 3's medical record revealed: *He had been admitted on 2/5/15. *The 2/5/15 transfer form from another provider indicated "Code status: Full Code." *A 9/3/14 healthcare power of attorney form signed by resident 3 listing two sons as appointed powers of attorney "to consent to, reject, or to withdraw consent for medical procedures, treatment, or intervention." *A 9/3/14 living will declaration signed by the resident indicated "With respect to life-sustaining treatment, I direct the following: -A check mark had been marked by the sentence, "If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain." -A check mark had been marked by the sentence, "I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent or I become permanently unconscious." -No further instructions had been listed below the above statement. *His last reviewed 2/23/15 care plan had listed 	F 281	<p>F281</p> <ol style="list-style-type: none"> The facility has updated it's Code Blue policy to reflect the American Heart Association guidelines for initiating CPR. The facility has also educated RN's A and C on the proper policy and procedures when dealing with a Code Blue. <i>10-7-15 AK</i> All residents are at risk. The Director of Nursing will in-service all staff who may discover an individual without a pulse, heartbeat, and not breathing and about their accountability and expectations during a Code Blue. The in-service will be completed no later than September 29th, 2015. The Director of Nursing/Designee will complete audits weekly x 4 and monthly x3 to insure that all individuals that may come into contact with a Code Blue know the policy/correct procedures to follow for resuscitation if the resident had requested to be resuscitated. Results of the audits will be reported by the DNS and discussed at the monthly Quality Assessment and Assurance for further review and Recommendations and/or continuation/discontinuation of audit. <i>10-7-15 AK</i> 	10-16-2015

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F 281	<p>Continued From page 14</p> <p>additional problems/interventions: "Yes Code Status."</p> <p>*A page at the front of the paper chart contained an adhesive sticker indicating "YES CODE."</p> <p>Review of RN A documentation in Care Coordinator Notes regarding resident 3:</p> <p>*On 7/26/15 at 8:00 p.m. she had given the resident his medication; he had eaten a protein bar at that time.</p> <p>-At 9:00 p.m. she had performed a dressing change on him, and he had participated with repositioning.</p> <p>*On 7/27/15 between 3:30 a.m. and 4:00 a.m. staff had checked on him and changed his brief. He had voided into a urinal during his scheduled rounds.</p> <p>*On 7/27/15 at 5:00 a.m. he was found sitting on the floor next to his bed.</p> <p>RN A's assessment notes on 7/27/15 at 5:00 a.m. regarding resident 3 revealed:</p> <p>*His pulse was absent.</p> <p>*His skin was cool to the touch and very pale/white in color with purple lips.</p> <p>*He was limp and unresponsive.</p> <p>*His pupils were fixed and nonresponsive.</p> <p>*There was no audible heart beat heard when listening through a stethoscope (a device with earpieces used to amplify noise) for one minute.</p> <p>*There was no obvious injury such as bruising, lacerations (cuts), or bumps.</p> <p>*Staff had lifted him onto his bed.</p> <p>*She contacted the immediate supervisor case manager (RN B) who had directed her to contact the director of nursing (DON).</p> <p>*She contacted the DON who had directed her to contact the emergency department (ED) at the provider's hospital with information.</p>	F 281		

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F 281	<p>Continued From page 15</p> <p>*She called the ED and informed the nursing supervisor at the ED that the "resident is a full code and was found sitting on the floor with no pulse and no breath sounds noted and that the DON inform writer not to use the standing order for a release of body."</p> <p>*She received an order for the release of the body from the ED supervisor after the supervisor had contacted the on-call physician for that order.</p> <p>*The ED supervisor called back and informed staff the police needed to be notified due to the "unexpected death."</p> <p>*Police arrived at 6:00 a.m.</p> <p>*Ambulance personal arrived at 6:05 a.m. to check for signs of life.</p> <p>*After the police were contacted five family members were contacted with information on the resident's status.</p> <p>Interview on 9/1/15 at 10:55 a.m. with household coordinator E revealed: *When asked how she would know if a resident had orders for full code resuscitation she would either: -Look for resuscitation orders in the medical record on the computer. 'Full code' meant the staff were to have attempted to resuscitate the resident. -Look in the resident's care plan. If the care plan had indicated 'Yes Code status', it had meant the staff were to have attempted to resuscitate the resident. -Look on the face of the chart for a green dot that indicated staff were to resuscitate them.</p> <p>Interview on 9/1/15 at 3:05 p.m. with the director of nursing (DON) regarding the events on 7/26/15 and 7/27/15 with resident 3 revealed: *She was aware resident 3 had orders for full</p>	F 281			

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F 281	<p>Continued From page 16</p> <p>code resuscitation.</p> <p>*She and other facility staff had visited with the resident's medical power of attorney (POA) and other family members on 6/30/15, 7/1/15, 7/2/15, 7/6/15, and 7/16/15 regarding his overall physical and mental declines.</p> <p>*They had encouraged the family to change his code status from "full code" to "do not resuscitate".</p> <p>*The physician's assistant had also visited with the family about changing the code status.</p> <p>-She was unable to locate documentation of that visit in the medical record.</p> <p>*The family had thought the resident had already changed the code status to DNR prior to being admitted to the provider's facility.</p> <p>*The POA had agreed the code status should have changed but wanted to visit with other family members and with the resident before making the change.</p> <p>*The POA or other family members had not visited with him about changing the status before he expired.</p> <p>Interview on 9/1/15 at 4:00 p.m. with RN A regarding the above events of 7/26/15 and 7/27/15 revealed:</p> <p>*During her medication pass and dressing change with resident 3 there were no signs of a change in condition.</p> <p>*He had exhibited some confusion for a few days prior to the event, but he had responded to her as she was caring for him.</p> <p>*She had last seen resident 3 around 10:30 p.m. The certified nursing assistants (CNA) had done resident rounds every two hours.</p> <p>*CNA D had called for help between 4:30 a.m. and 5:00 a.m.</p> <p>*She had entered resident 3's room and found</p>	F 281			

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F 281	<p>Continued From page 17</p> <p>him sitting on the floor.</p> <p>*She reached to remove his C-PAP (continuous positive airway pressure) (used to assist with breathing) mask and could see that he had expired.</p> <p>*She wanted him placed on the bed. so she called for other nurses in the building for assistance.</p> <p>*She could not find a pulse, heartbeat, or blood pressure. The pupils of his eyes were fixed and dilated (enlarged).</p> <p>*He was "not cold but not warm like he had been earlier."</p> <p>*She was unable to lift so she left the room to assist another resident while the CNAs and nurse lifted him onto the bed.</p> <p>**"I was in shock because it was totally unexpected."</p> <p>*She had not known he had orders for full code resuscitation, but RN C knew he was full code and had told her.</p> <p>*She asked RN C if she should gather CPR/AED equipment, and she told her "no, that he was already gone."</p> <p>**"So then I called [the nursing supervisor] [RN B)], who told me to call [the DON], and she said to call the ER [hospital emergency department]."</p> <p>*None of the above had instructed her to begin resuscitating the resident.</p> <p>*Although he had exhibited physical and mental declines for the past few weeks she did not believe his death was imminent (about to occur at any moment), because it had been unexpected to her.</p> <p>*When asked why she had not started CPR she stated, "He was white. He was gone."</p> <p>*She had not seen any rigor mortis (stiffness of the joints after death), or mottling (pooling of blood causing purple/black discoloration).</p>	F 281			

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F 281	<p>Continued From page 18</p> <p>Interview on 9/1/15 at 4:20 p.m. in a phone call with resident 3's physician and the provider's medical director revealed: *He had not been surprised by resident 3's death due to gradual overall declines. *He believed the resident probably had a heart attack. *He stated the nursing staff responded appropriately by not starting resuscitation attempts. *It was "quite apparent he needed to be DNR [do not resuscitate], but that [obtaining the DNR orders] had not been accomplished." *The resident did not have the mental capacity to make the decision regarding his resuscitation. *The physician's "opinion is CPR doesn't work for this age group." **"I know there are a certain set of rule to abide by, but we need common sense as well."</p> <p>Interview on 9/1/15 at 5:30 p.m. with CNA D revealed: *He had been working the night resident 3 had expired. *He had assisted with the resident's care at least every one and one-half to two hours. *The resident called often for a urinal. *He had found the resident on the floor, checked for a pulse, and called for help. *No one had attempted to start CPR. **"The nurse had said he was cool so nothing could be done." *No one called 911 until they called the emergency room and were instructed to get the police involved.</p> <p>Interview on 9/2/15 at 8:20 a.m. with nursing supervisor B revealed:</p>	F 281		

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F 281	<p>Continued From page 19</p> <p>*She was the nursing supervisor in charge of resident 3.</p> <p>*She had not been working the night of 7/26/15 - 7/27/15.</p> <p>*There were no nurses on-call for emergencies.</p> <p>*RN A had called her to tell her what had happened to resident 3.</p> <p>*She had told RN A to call the DON.</p> <p>*She was aware that resident 3 had orders for a full code resuscitation.</p> <p>*She had been involved with the DON during visits with the POA regarding getting his code status changed.</p> <p>*She had never visited with resident 3 about his wishes regarding his resuscitation status, because the family wanted to talk to him about it.</p> <p>*Resident 3 had some episodes of confusion but would have been able to verbalize his resuscitation wishes to his son.</p> <p>*When RN A called her on 7/27/15 she (nursing supervisor B) had not told RN A resident 3 was a full code resuscitation.</p> <p>*She had assumed RN A had known he had full code orders.</p> <p>*When asked about full code resuscitation she stated, "If a resident is cool, I am not going to start CPR in a nursing home. You can do so much damage with CPR."</p> <p>*When asked if she felt resident 3's death was imminent she stated he had a bad heart and could have had a heart attack at any time.</p> <p>Interview on 9/2/15 at 8:40 a.m. with RN C revealed:</p> <p>*She had been working on another neighborhood unit on the night of 7/26/15 - 7/27/15.</p> <p>*She had received a call about 5:00 a.m. from one of the CNAs to "come right away to [neighborhood room #] because someone was on</p>	F 281			

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F 281	<p>Continued From page 20</p> <p>the floor." *"They didn't tell me he was unresponsive or anything." *She had been drawing blood from another resident, so she finished what she was doing, cleansed her hands, and put things away. It had taken her approximately five minutes to finish her work. *The resident was on the floor when she entered the room, and they lifted him onto the bed. *RN C had not been told the resident had expired. *She had not known he had orders for a full code resuscitation. *She proceeded to clean the resident. *RN A had not been in the resident's room. She had been making phone calls in the nursing area. *When RN A came into the resident's room she told RN C he was a full code status. *RN C stated she had already been in the room fifteen minutes before she had been told of the status. *"I told her he was already gone." *"I called the ED and told them to call an ambulance. The ambulance was already on the way." *There was no rigor mortis. *There was some mottling, "More like a pink flushed color on his cheeks, face, and hands. He was always flushed. His legs had a purple color. But he had very bad circulation." *She stated if she were his nurse and had known he had full code resuscitation orders she would not have initiated CPR, because he was cold and had some mottling.</p> <p>Interview on 9/2/15 at 9:30 a.m. with the DON revealed: *She believed her nurses had followed the</p>	F 281			

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F 281	<p>Continued From page 21</p> <p>provider's policy for resuscitation/code blue, because the policy stated that at times it was necessary to deviate from the procedure based on the status of the patient (resident) and judgment of the nursing staff regarding a resident's status.</p> <p>*She agreed emergency services had not been contacted appropriately for a full code resident with an absent pulse, heartbeat, and breathing.</p> <p>*She had not instructed RN A to begin resuscitation efforts when she had called on 7/27/15.</p> <p>*She had not visited with resident 3 regarding his wishes for resuscitation, because the family wanted to visit with him.</p> <p>*A BIMS (brief interview for mental status) test had not been conducted for resident 3 since 5/20/15, when the score had been 14 (indicating his mental status was intact at that time).</p> <p>*He had exhibited recent periods of confusion.</p> <p>*She was aware of the American Heart Association's guidelines for when resuscitation should not occur, but they were only guidelines, and the provider's policy had allowed room for deviation.</p> <p>*She understood the resident's wishes had not been followed according to the living will declaration he had signed.</p> <p>*There was a very fine line for nursing to make decisions on behalf of the resident.</p> <p>Review of the provider's August 2013 Code Blue policy revealed:</p> <p>*Patient care policies and procedures were written to guide staff in providing direct care.</p> <p>*At times it was necessary for staff to deviate from the established procedure.</p> <p>*Deviation would be based on the clinical needs/status of the patient, and the judgement of</p>	F 281			

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F 281	<p>Continued From page 22</p> <p>the staff determined to be in the best interest of the patient.</p> <p>*A staff member would initiate the code using the overhead paging system announcing "code blue" followed by the location of the room.</p> <p>*Nursing staff would gather supplies (back board, oxygen, AED), dial 911, and notify the family and physician.</p> <p>*CPR and AED use would continue per American Heart Association guidelines until care was taken over by the ambulance staff.</p> <p>Review of Laurie J. Morrison et al, Part 3: Ethics: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, WWW. http://circ.ahajournals.org/content/122/18_suppl_3/S665.full.pdf+html, accessed on 9/3/15 revealed:</p> <p>Criteria for Not Starting CPR in all OHCA (out-of-hospital cardiac arrest:</p> <p>***While the general rule is to provide emergency treatment to a victim of cardiac arrest, there are a few exceptions where withholding CPR might be appropriate as follows:</p> <p>-Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril.</p> <p>-Obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition).</p> <p>-A valid signed, and dated advance directive indicating that resuscitation is not desired, or a valid, signed, and dated DNAR order."</p> <p>Review of the provider's May 2000 policy for Do Not Resuscitate (DNR) revealed:</p> <p>***The competent person should be encouraged to discuss his or her desires in regards to the</p>	F 281		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/02/2015
NAME OF PROVIDER OR SUPPLIER THE NEIGHBORHOODS AT BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 2421 YORKSHIRE DR BROOKINGS, SD 57006		
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F 281	Continued From page 23 resuscitation or life-sustaining measures with his/her personal physician and family members." *The person's decision would be respected above the desires of the family or anyone else unless this decision was deemed to be irrational or otherwise in violation of policies. *If there was family disagreement as to the person's decision on no code status, this was to have been brought to the attention of administration and the Ethics Committee as appropriate. **An incompetent person should be involved in the decision making process in regards to his or her care and treatment to the extent of his capacity. ***If the incompetent person has previously, while being competent, presented an appropriate advance directive containing his or her wishes regarding life-sustaining measures, then those wishes should be respected unless deemed inappropriate, irrational, or otherwise in violation of policy or state law." *If no family members are available, after reasonable efforts are made to identify and contact such members, and the attending physician thinks that there may be potential question regarding prognosis of the person, the Ethics Committee may be asked to review the case and express its opinions regarding life-sustaining measures. **If an appropriate personal representative is in a position to make a decision for the incompetent person, or if there is a disagreement among other family members, the matter will be reported to the nursing home administrator and, if appropriate, the Ethics Committee may be convened." **"Do not resuscitate" requires a physician's order." **2 c. The physician's progress notes in writing or	F 281			

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F 281	Continued From page 24 dictation will reflect evidence that the physician had discussed the decision with the patient and that they have mutually reached a decision." **3. If the patient is judged by the physician not to have the capacity to make decisions, that fact should be documented along with other evidence supporting the decision not to resuscitate" **In cases where cardiopulmonary resuscitation would be clearly futile [a treatment is clearly futile...if it will not achieve it's physiologic objective and so offers no physiologic benefit to the patient."] the physician may issue a DNR order without item 2 c or 3 above. Reasonable efforts should be made to inform the patient or surrogate of this decision. The physician should document "clear futility" in the medical record."	F 281		
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