STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. BUILDING _____ B. WING _____	**02/05/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATTALLA HEALTH AND REHAB	**915 STEWART AVENUE SOUTHEAST ATTALLA, AL 35954**

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 0155 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Let the resident refuse treatment or refuse to take part in an experiment and formulate advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of Resident Identifier (RI) #1's medical record, Fundamentals of Nursing and the 2010 American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, Employee Identifier (EI) #2, a Licensed Practical Nurse (LPN), failed to honor the resident rights of Resident Identifier (RI) #1, a resident with Full Code status. Code status describes what type of intervention a health care facility will conduct should a resident stop breathing and/or their heart stops beating. Full Code status means when a resident stops breathing and/or their heart stops beating, staff are to immediately initiate emergency medical services, Cardiopulmonary Resuscitation (CPR), in an attempt to revive the resident. During the 3:00 p.m. - 11:00 p.m. shift on [DATE], EI #1, a Certified Nursing Assistant (CNA), entered RI #1's room and found the resident without a pulse. EI #1 then informed EI #2, the LPN Charge Nurse. EI #2 went to the door of RI #1's room, looked in and saw that RI #1 looked pale. Instead of assessing RI #1's condition and activating the emergency response system, EI #2, who was CPR certified, left the resident's room door and went to the nurses' station to call the Registered Nurse (RN) Supervisor, EI #3. After EI #3 walked to the side of the facility where RI #1's room was located, she initiated the activation of the emergency response system and started CPR on RI #1, a resident with Full Code status. According to the AHA, the lone rescuer should immediately activate the emergency response system, get an AED (Automated External Defibrillator)/defibrillator, if available, and start CPR with chest compressions. CPR should be continued without interruptions until more experienced rescuers assume care. This deficient practice affected RI #1, one of three sampled residents reviewed for emergency response, and placed RI #1 in immediate jeopardy of serious injury, harm or death. On [DATE] at 6:11 p.m., the facility's Interim Administrator and Director of Nursing were notified of the findings of immediate jeopardy in the area of Resident Rights, F 155. Findings include: Cross reference F 309 The 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care with a copyright date of 2010 documented . Part 4: CPR Overview . The Universal Adult Basic Life Support (BLS) Algorithm is a conceptual framework for all levels of rescuers in all settings. It emphasizes the key components that any rescuer can and should perform. When encountering a victim of sudden adult [MEDICAL CONDITION], the lone rescuer must first recognize that the victim has experienced a [MEDICAL CONDITION], based on unresponsiveness and lack of normal breathing. After recognition, the rescuer should immediately activate the emergency response system, get an AED (Automated External Defibrillator), if available, and start CPR with chest compressions . Page 853 of Potter and Perry Fundamentals of Nursing Eighth Edition with a copyright date of 2013, documented: . Restoration of Cardiopulmonary Functioning . A [MEDICAL CONDITION] is a sudden cessation of cardiac output and circulation . A lone health care provider who sees an adult in [MEDICAL CONDITION] should activate the emergency response system, get and use an automatic external defibrillator (AED) if available, and give CPR . On [DATE], the State Agency received a complaint regarding the care RI #1 received on [DATE]. According to the complainant, she received an anonymous call on [DATE] that stated RI #1 died in the facility as the result of staff negligence. RI #1 was admitted to the facility on [DATE] with a medical history to include: [MEDICAL CONDITION], Hypoxic Ischemic [MEDICAL CONDITION], Heart Failure and [MEDICAL CONDITION]. RI #1's physician's orders [REDACTED]. . CODE STATUS: Full . RI #1's physician's orders [REDACTED].#1 had Full Code status. On [DATE] at 12:28 p.m., an interview with EI #1, the CNA who found RI #1 without a pulse during the 3p - 11p shift on [DATE] was conducted. EI #1 explained that when she entered RI #1's room, she checked the resident for a pulse and RI #1 did not have a pulse. EI #1 said she went to the nurse (EI #2, the LPN Charge Nurse) and informed the nurse that she could not find a pulse on RI #1. On [DATE] at 9:22 a.m., an interview was conducted with EI #2, the LPN assigned to care for RI #1 during the 7a - 7p shift on [DATE]. EI #2 was asked, if RI #1 was a Full Code. EI #2 said, yes. On [DATE] at 3:21 p.m., an interview with EI #3, the RN Supervisor on [DATE] was conducted. EI #3 was asked, what did the AHA CPR guidelines instruct staff to do when they find a resident unresponsive. According to EI #3, the staff should know if the person is a code (Full Code) or no code (DNR/Do Not Resuscitate). EI #3 said if the person is a code, the staff should start CPR. EI #3 was asked if EI #2 initiated CPR on RI #1. EI #3 replied, No. In a follow-up telephone interview on [DATE] at 1:58 p.m., EI #3 (RN Supervisor) acknowledged that when EI #2 (the LPN) met her in the hallway, EI #2 told her that she did not think RI #1 was breathing. EI #3 further acknowledged that EI #2 had not called a code blue. When asked, if she asked the LPN (EI #2), why a code was not called. EI #3 said, No. EI #3 said she did not think to ask EI #2 why she had not called a code when she found RI #1 unresponsive. When asked, what should have been done, EI #3 replied, She (EI #2) should have gone in the room, checked for a pulse and then called a code. ********** On [DATE] at 6:44 p.m., the facility submitted an Allegation of Credible Compliance, which documented: This allegation of credible compliance is being submitted in compliance with specific regulatory requirements. The preparation and or execution of this allegation of credible compliance does not constitute admission of agreement by the provider of the facts alleged and conclusions set forth. Please accept this credible allegation of compliance as the facilities written credible allegation that the alleged deficiencies to be cited have been corrected by the date or dates indicated. F 155 1. RI #1, a resident with wishes to be a full code expired in route to hospital on [DATE]. 2. All residents with wishes to be a full code, charts were audited on [DATE] by the DON (Director of Nursing) and unit managers to ensure the residents chart reflected the residents wish to be a full code. All charts audited contained or reflected the residents code status wish. 3. All staff were re-educated by DON/designee on honoring residents rights who wishes to be a full code. This was completed on [DATE]. 4. No residents have expired in the facility since [DATE].

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

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 0155 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) ********** After reviewing the facility's information provided in their Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 155 was lowered to D level on [DATE], to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL 249.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of Resident Identifier (RI) #1's medical record, the facility's policy titled Cardiopulmonary Resuscitation (CPR) and Basic Life Support and the 2010 American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, the facility failed to ensure Employee Identifier (EI) #2, a Licensed Practical Nurse (LPN) assessed the condition of RI #1 after a CNA (Certified Nursing Assistant) was reported to her that RI #1, a resident with Full Code status, did not have a pulse. EI #1 also failed to follow the AHA guidelines for providing Cardiopulmonary Resuscitation to RI #1, a resident with Full Code status. Code status describes what type of intervention a health care facility will conduct should a resident stop breathing and/or their heart stops beating. Full Code status means when a resident stops breathing and/or their heart stops beating, staff are to immediately initiate emergency medical services, CPR, in an attempt to revive the resident. According to the AHA, the lone rescuer should immediately activate the emergency response system, get an AED (Automated External Defibrillator)/defibrillator, if available, and start CPR with chest compressions. CPR should be continued without interruptions until more experienced rescuers assume care. During the 3:00 p.m. - 11:00 p.m. shift on [DATE], EI #1, a CNA reported to EI #2, the LPN, that RI #1 did not have a pulse. Instead of assessing the resident's condition, EI #2 looked at RI #1 from the resident's doorway, turned around and walked down the hall to the nurses' station. EI #2 did not immediately activate the emergency response system or call a code. Instead, EI #2 made a non-emergent call for the Registered Nurse (RN) Supervisor (EI #3) to come to the side of the facility where RI #1 resided. When EI #2 met EI #3 walking down the hall, EI #2 informed EI #3 that she did not think RI #1 was breathing. After EI #3 entered RI #1's room, EI #3 assessed the resident's condition, initiated CPR and directed EI #2 to activate the emergency response system (911) and to call all available nurses for assistance. These deficient practices affected RI #1, one of three sampled residents reviewed for emergency response, and placed RI #1 in immediate jeopardy of serious injury, harm or death. On [DATE] at 6:11 p.m., the facility's Interim Administrator and Director of Nursing were notified of the findings of substandard quality of care at immediate jeopardy in the area of Quality of Care, F 309. Findings include: On [DATE], the State Agency received a complaint regarding the care RI #1 received on [DATE]. According to the complainant, she received an anonymous call on [DATE] that stated RI #1 died in the facility as the result of staff negligence. The facility's policy titled Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) with a revised date of [DATE], documented: Purpose The purpose of this procedure is to provide guidelines for the initiation of Cardiopulmonary Resuscitation (CPR)/Basic Life Support (BLS) in victims of sudden [MEDICAL CONDITION] . General Guidelines 1. [MEDICAL CONDITION] is defined as inadequate cardiac contractions resulting in insufficient blood flow throughout the body (pulselessness) . 8. The goal of early delivery of CPR is to try to maintain life until the emergency medical response team arrives to deliver Advanced Life Support (ALS). 9. If an individual (resident, visitor, or staff) is found unresponsive and not breathing normally, a licensed staff person who is certified in CPR/BLS shall initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order . Steps in the Procedure The facility's procedure for administering CPR shall incorporate the steps covered in the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care . The 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care with a copyright date of 2010 documented . Part 4: CPR Overview . The Universal Adult Basic Life Support (BLS) Algorithm is a conceptual framework for all levels of rescuers in all settings. It emphasizes the key components that any rescuer can and should perform. When encountering a victim of sudden adult [MEDICAL CONDITION], the lone rescuer must first recognize that the victim has experienced a [MEDICAL CONDITION], based on unresponsiveness and lack of normal breathing. After recognition, the rescuer should immediately activate the emergency response system, get an AED (Automated External Defibrillator), if available, and start CPR with chest compressions. If an AED is not close by, the rescuer should proceed directly to CPR. If other rescuers are present, the first rescuer should direct them to activate the emergency response system and get the AED/defibrillator; the first rescuer should start CPR immediately . If an AED/defibrillator is not available, continue CPR without interruptions until more experienced rescuers assume care . rescuers should start CPR immediately if the adult victim is unresponsive and not breathing or not breathing normally . CPR improves the victim's chance of survival by providing heart and brain circulation. Rescuers should perform chest compressions for all victims in [MEDICAL CONDITION], regardless of rescuer skill level, victim characteristics, or available resources . RI #1 was admitted to the facility on [DATE] with a medical history to include: [MEDICAL CONDITION], Hypoxic Ischemic [MEDICAL CONDITION], Heart Failure and [MEDICAL CONDITION]. RI #1's physician's orders [REDACTED]. . CODE STATUS: Full . RI #1's physician's orders [REDACTED].#1 had Full Code status. On [DATE] at 12:28 p.m., an interview was conducted with EI #1, the CNA who found RI #1 without a pulse during the 3p - 11p shift on [DATE]. EI #1 said when she entered RI #1's room, RI #1 looked pale, and when checked, the resident did not have a pulse. EI #1 said she went to the nurse, EI #2 (LPN Charge Nurse), and informed her she could not find a pulse on RI #1. On [DATE] at 9:22 a.m., an interview was conducted with EI #2, the LPN assigned to care for RI #1 during the 7a - 7p shift on [DATE]. According to EI #2, around 3:45 p.m./4:00 p.m., she was at the nurses' station when a CNA came and informed her that RI #1 did not have a pulse. Instead of going into RI #1's room, EI #2 acknowledged she stood in the resident's doorway and noticed RI #1 was pale in color. EI #2 did not assess RI #1's condition or check the resident's vital signs after EI #1 reported to her that RI #1 did not have a pulse. EI #2 left RI #1's doorway and proceeded to the nurses' station to call the nursing supervisor, EI #3. EI #2 paged overhead for the supervisor, EI #3, to come to the hall where RI #1 resided. EI #2 did not call code blue, as indicated in the facility's policy. As EI #2 was walking back to RI #1's room, she observed EI #3 walking from the other hall. According to EI #2, she told EI #3 that she needed her to come to RI #1's room. EI #2 said when she and EI #3 entered RI #1's room they assessed the resident's vitals. EI #3 assessed RI #1's pulse and told EI #2 to go and find out what RI #1's code status was. When asked, what RI #1's code status was, EI #2 said RI #1 was a Full Code. When asked, who initiated CPR, EI #2 stated she did not know as she was at the nurses' station making copies. EI #2 was asked, why she did not enter RI #1's room to assess the resident. EI #2 said she felt like RI #1's color was pale and she needed to get another nurse to help her. EI #2 was asked, what did the AHA CPR guidelines state should be done when a person is found unresponsive. EI #2 said, she thought the guidelines said to call for help. When asked, what could have been done differently for RI #1, EI #2 said she did not know what she could have done differently. According to EI #2, she has been a licensed nurse for [AGE] years. EI #2's personnel file revealed she was certified in Basic Life Support for Healthcare Providers/CPR and AED Program on [DATE], with an expiration date of [DATE]. In a follow-up interview on [DATE] at 10:44 a.m., EI #2 said what she could have done differently, was to ring RI #1's call light for help in the resident's room. On [DATE] at 3:21 p.m., the surveyor conducted an interview with EI #3, the RN Supervisor on [DATE]. The surveyor asked EI #3 can an unresponsive resident be assessed from the doorway of a room. EI #3 said, no. According to EI #3, when the CNA (EI #1) informed EI #2 (the LPN) that RI #1 was pale and without a pulse, EI #2 should have gone into RI #1's room to assess the resident. EI #3 was asked, what the AHA CPR guidelines instructed a staff to do when they find a resident unresponsive. EI #3 said if the person is a Full Code you should start CPR. When asked if EI #2 initiated CPR, EI #3 replied, No. EI #3 said CPR was initiated after she assessed RI #1 and found the resident without breath sounds, a heartbeat or a pulse. EI #3 explained how she started chest compressions and told EI #2 to go to the desk and call all available nurses and 911.

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) In a follow-up telephone interview on [DATE] at 1:58 p.m., EI #3 acknowledged that when EI #2 (the LPN) met her in the hallway, EI #2 told her that she did not think RI #1 was breathing. EI #3 further acknowledged that EI #2 had not called a code blue. When asked, if she asked the LPN (EI #2), why a code was not called. EI #3 said, No. EI #3 said she did not think to ask EI #2 why she had not called a code when she found RI #1 unresponsive. When asked, what should have been done, EI #3 replied, She (EI #2) should have gone in the room, checked for a pulse and then called a code. On [DATE] at 8:02 a.m., EI #6, the Staff Educator stated CPR was reviewed in staff orientation. EI #6 explained that it was the charge nurse's responsibility to take charge in an emergency situation. EI #6 was asked, what should staff do if they find a resident unresponsive. EI #6 said if a resident is found unresponsive, the nurse would go in and assess the resident. EI #6 further stated, if a code should be called, the nurse should pull the call light to activate the emergency light. When a staff member responds to the call light, the charge nurse should instruct the staff to call code blue and activate the emergency response system (911). The charge nurse should immediately start chest compressions and as others come, designate other duties as needed. When asked if a resident could be assessed from the doorway, EI #6 said no. In an interview on [DATE] at 8:43 a.m., EI #7, the RN Unit Manager was asked, what did the facility's policy dictate the nurse to do if a resident was found unresponsive and without a pulse. EI #7 said, if a resident was found unresponsive or without a pulse, the nurse should call for help, go ahead and start chest compressions and once someone comes to the door designate that a code and 911 be called. During an interview with the EI #5, the Director of Nursing on [DATE] at 10:17 a.m., she acknowledged the appropriate steps a nurse should take when a resident is found without a pulse. EI #5 said, the nurse who found a resident unresponsive should immediately do a tactile, visual assessment to determine the status of the resident. The nurse should immediately start CPR if the resident is found without a pulse or respiration. The nurse should call for help, by pulling the call light out of the wall for assistance. The nurse should follow the protocol for CPR. EI #5 was asked, what the AHA guidelines dictated a first responder to do. EI #5 said, do not leave your resident. When asked, what should EI #2 have done, EI #5 replied, EI #2 should have gone in RI #1's room and assessed the resident. ********** On [DATE] at 6:44 p.m., the facility submitted an Allegation of Credible Compliance, which documented: This allegation of credible compliance is being submitted in compliance with specific regulatory requirements. The preparation and or execution of this allegation of compliance does not constitute admission of agreement by the provider of the facts alleged and conclusions set forth. Please accept this credible allegation of compliance as the facilities written credible allegation that the alleged deficiencies to be cited have been corrected by the date or dates indicated. F309 1. The LPN responsible for the care of RI #1 on [DATE] was given 1 on 1 inservice on [DATE] on how to respond when a resident is found without a pulse and how to immediately activate the Emergency Response System (ERS). 2. All licensed staff except three were re-educated on what to do when a resident is found without a pulse and how to immediately activate the ERS. This was completed on [DATE] by the DON, unit managers, and staff development. The three licensed staff who have not been educated will not work until the education has occurred. 3. The DON/designee did a mock code on [DATE] and [DATE] to ensure all licensed staff responding to residents with wishes to be a full code were able to initiate CPR/basic life support. Return demonstration was done on [DATE] and [DATE]. All licensed staff involved in the mock code were able to demonstrate and acknowledge when basic CPR was to be initiated. 4. Don/designee reviewed the personnel files of all licensed staff to ensure they were CPR certified. All reviewed licensed personnel files reflected CPR certifications were up to date. This was completed on [DATE]. On [DATE], the facility updated the policy to reflect all licensed staff should respond to residents with wishes to be a full code and should initiate CPR/basic life support immediately. ********** After reviewing the facility's information provided in their Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 309 was lowered to D level on [DATE], to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL 249.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of Employee Identifier (EI) #3's job description and Fundamentals of Nursing, EI #3, the Registered Nurse Supervisor failed to inform the Administrative Staff that the Cardiopulmonary Resuscitation (CPR) was not immediately initiated and the emergency response system (911) was not immediately activated when Resident Identifier (RI) #1, a resident who was Full Code status, was initially found without a pulse on [DATE]. During the 3:00 p.m. - 11:00 p.m. shift on [DATE], EI #1, a Certified Nursing Assistant (CNA) reported to EI #2, the LPN, that RI #1 did not have a pulse. Instead of assessing the resident's condition, EI #2 looked at RI #1 from the resident's doorway, turned around and walked down the hall to the nurses' station. EI #2 did not immediately activate the emergency response system or call a code. Instead, EI #2 made a non-emergent call for the Registered Nurse (RN) Supervisor (EI #3) to come to the side of the facility where RI #1 resided. When EI #2 met EI #3 walking down the hall, EI #2 informed EI #3 that she did not think RI #1 was breathing. After EI #3 entered RI #1's room, she assessed the resident's condition, initiated CPR and directed EI #2 to activate the emergency response system (911) and to call all available nurses for assistance. This deficient practice affected RI #1, one of three sampled resident reviewed for emergency response, and placed RI #1 in immediate jeopardy of serious injury, harm or death. On [DATE] at 6:11 p.m., the facility's Interim Administrator and Director of Nursing were notified of the findings of immediate jeopardy in the area of Administration, F 490. Findings include: Cross reference F 155 and F 309 Unit 3 titled Critical Thinking in Nursing Practice page 245 of Chapter 18 titled Planning Nursing Care of Potter and Perry Fundamentals of Nursing Eighth Edition with a copyright date of 2013, documented . Change of Shift . It is a critical time when nurses collaborate and share important information that ensures the continuity of care for a patient and prevents errors or delays in providing nursing interventions . EI #3's CHARGE NURSE - RN Job description date ,[DATE], documented: . LANGUAGE, MATHEMATICAL & REASONING SKILLS . Ability to effectively present information to top management . Residents' Rights Functions *Understands, compliance and promotes all rules regarding Resident's Rights . In an interview on [DATE] at 12:28 p.m., EI #1 (the Certified Nursing Assistant) stated when she entered RI #1's room, RI #1 looked pale, and when checked, the resident did not have a pulse. EI #1 said she went to the nurse, EI #2 (LPN Charge Nurse), and told her she could not find a pulse on RI #1. On [DATE] at 9:22 a.m., an interview was conducted with EI #2, the LPN assigned to care for RI #1 during the 7a - 7p shift on [DATE]. According to EI #2, around 3:45 PM/4:00 PM, she was at the nurses' station when a CNA came and informed her that RI #1 did not have a pulse. Instead of going into RI #1's room, EI #2 acknowledged that she stood in the resident's doorway and noticed that RI #1 was pale in color. EI #2 did not assess RI #1's condition or check the resident's vital signs after she was informed by EI #1 that RI #1 did not have a pulse. EI #2 left RI #1's doorway and proceeded to the nurses' station to call the nursing supervisor, EI #3. EI #2 paged overhead for the supervisor, EI #3, to come to the hall where RI #1 resided. EI #2 did not call code blue, as indicated in the facility's policy. As EI #2 was walking back to RI #1's room, she observed EI #3 walking from the other hall. According to EI #2, she told EI #3 that she needed her to come to RI #1's room. EI #2 said when she and EI #3 entered RI #3's room they assessed RI #1's vitals. EI #3 assessed RI #1's pulse and told EI #2 to go and find out what RI #1's code status was. When asked, who initiated CPR, EI #2 stated she did not know as she was at the nurses' station making copies. EI #2 was asked, why she did not enter RI #1's room to assess the resident. EI #2 said she felt like RI #1's color was pale and she needed to get another nurse to help her. On [DATE] at 3:21 p.m., the surveyor conducted an interview with EI #3, the RN Supervisor on [DATE]. The surveyor asked EI #3 can an unresponsive resident be assessed from the doorway of a room. EI #3 said, no. According to EI #3, when the CNA informed EI #2 that RI #1 was pale and without a pulse, EI #2 should have gone into RI #1's room to assess the resident. EI

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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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) #3 was asked, what the AHA CPR guidelines instructed a staff to do when they found a resident unresponsive. EI #3 said if the person is Full Code you should start CPR. When asked if EI #2 initiated CPR, EI #3 replied, No. EI #3 said CPR was initiated after she assessed RI #1 and found the resident without breath sounds, a heartbeat or a pulse. EI #3 explained how she started chest compressions and told EI #2 to go to the desk and call all available nurses and 911. On [DATE] at 10:17 a.m., an interview was conducted with EI #5, the Director of Nursing (DON). EI #5 acknowledged that she was informed on Monday, [DATE] that RI #1 had expired. According to EI #5, EI #3 (the RN Supervisor) told her that RI #1 crashed, CPR was started, 911 was called and RI #1 was sent to a local hospital per the family's preference. In a follow-up telephone interview on [DATE] at 1:58 p.m., EI #3 was asked if she informed EI #5 (DON) when she talked with her on Monday ([DATE]) that EI #2 (the LPN) did not call a code when RI #1 was initially found pale, unresponsive and without a pulse. EI #3 said she did not remember if she did or not. In a follow-up interview on [DATE] at 5:25 p.m., EI #5 acknowledged that she was not informed by EI #3 (the RN Supervisor) that when the resident (RI #1) was initially found by EI #2 (the LPN) that the resident was not breathing. EI #5 was not aware that EI #2 had not called a code blue when the CNA (EI #1) first reported to EI #2 that RI #1 did not have a pulse. When asked, what she would have done if the events surrounding RI #1 being found without a pulse had been reported to her on Monday [DATE], EI #5 stated she would have begun an investigation relating to how to respond to an unresponsive resident. ********** On [DATE] at 6:44 p.m., the facility submitted an Allegation of Credible Compliance, which documented: This allegation of credible compliance is being submitted in compliance with specific regulatory requirements. The preparation and or execution of this allegation of credible compliance does not constitute admission of agreement by the provider of the facts alleged and conclusions set forth. Please accept this credible allegation of compliance as the facilities written credible allegation that the alleged deficiencies to be cited have been corrected by the date or dates indicated. F 490 1. The RN weekend supervisor in charge on [DATE] received 1 on 1 inservice on the importance of informing administrative staff when there has been a failure to initiate the ERS (emergency response system) correctly. This was completed by the DON. 2. A review of resident charts reveals that there has not been a need to activate the ERS since [DATE]. This review was completed on [DATE] by the DON and unit managers. 3. DON/designee educated all supervisors on [DATE] on the importance of informing administrative staff when there has been a failure to initiate the ERS correctly. On [DATE], an emergency response occurrence review form was developed by the administrative staff to be used when a code has been done to ensure the code was initiated correctly. 4. No residents have expired in the facility since [DATE]. ********** After reviewing the facility's information provided in their Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 490 was lowered to D level on [DATE], to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL 249.