

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00126288.</p> <p>Complaint IN00126288 - Substantiated. Federal/State deficiencies related to the allegation are cited at F309.</p> <p>Survey date: March 22, 2013</p> <p>Facility number: 000178 Provider number: 155280 AIM number: 100273840</p> <p>Survey team: Cheryl Fielden RN-TC</p> <p>Census bed type: SNF/NF: 97 Total: 97</p> <p>Census payor type: Medicare: 12 Medicaid: 73 Other: 12 Total: 97</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
---------	--	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Quality review 4/01/13 by Suzanne Williams, RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013	
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to provide cardiopulmonary resuscitation (CPR) to a resident who indicated they wished to be a full code status. This deficient practice affected 1 of 3 residents reviewed for resuscitation. (Resident #A) Resident #A went into cardiopulmonary arrest, did not have CPR performed, and died.</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 3/22/13 at 10:30 a.m. The record indicated the diagnoses included, but were not limited to, atrial fibrillation (irregular heartbeat), post abdominal wound-incisional hernia repair, coronary artery disease, and HTN (hypertension - high blood pressure).</p> <p>A form titled "Code Status Consent Form:" for Resident #A indicated "I (family member), have discussed with the attending physician, the general</p>	F000309	Preparation and / or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of correction and specific corrective actions are prepared and / or executed in compliance with state and federal laws. The facility respectfully requests paper compliance for this citation. It is the intent of this facility to honor the choice of our residents by initiating the code status that they have signed and requested. 1. Action Taken: a. Residents family and physician notified, DON and HFA notified of incident b. An audit of all other residents was conducted to ensure code status is in place. c. Nursing staff re-educated on code status and response to code status. 2. Others Identified: a. No others residents were affected. 3. Measures Taken: a. All nurses have been re-educated on CPR and code status and proper response to condition of resident.	03/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>nature of my/the resident's condition, the procedure, material risks, expected outcome and reasonable alternatives of the procedure and grant my consent to place myself or the resident on a specified code status...(marked with an X) 2. Full Code: a. Cardio-pulmonary resuscitative measures will be instituted in the event of cardiac arrest and/or respiratory arrest. CPR will be utilized," signed by Responsible Party on 3/7/13, signed by Facility Representative, dated 3/7/13.</p> <p>The admission physician orders, dated for 3/7/13 through 3/31/13, indicate a full code.</p> <p>Social Service Progress notes, noted an assessment reference date of 3/14/13 5d (day)/adm (admission) resident interview. The note indicated, "...BIMS score 15...Cognitive status is intact, was able to repeat the 3 words...on 1st attempt, stated the year '2013,' the month 'March' & the day of the week 'Thursday,' was able to recall the three words...Advance directive & Code status; Code status: Full Code, family member is POA (power of attorney), has a living will...."</p>		<p>b. The Director of Nursing or designee will run mock codes to evaluated response and actions taken, then out comes will be reviewed in the daily QA stand-up meeting. Any negative findings will be immediately addressed and a plan to correct any found problems or issues. This will be completed with-in four consecutive weeks with no negative findings and then monthly there after per the QA team. c. All Residents code status has been reviewed and was found to be current. d. It was found that the charge nurse for this resident did not meet professional standards for the care of this resident and employment has been terminated. The oncoming nurse was given a final written notice for not stepping up and taking charge or speaking out in a questionable situation of standard care. 4. How Monitored a. The CEO/Designee and DON will review all completed mock codes evaluations in the Daily QA stand-up meeting to ensure all issues were resolved and then at the quarterly QA meeting with the Medical Director. b. Mock codes will continue to be performed at least monthly to ensure resident needs are being met as part of the QA process. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3 23 13.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>Nurses' Notes indicated: "3/17/13 at 9:25 p.m.,...(symbol for no) S/S (signs and symptoms) distress. 3/17/13 at 11:00 p.m., right knee pain...PRN (as needed) pain med given... 3/18/13 at 5:45 a.m.,...c/o chest pain., (symbol for no) relief (symbol for after) 1:1 attempt to relax, M.D. notified N.O. rec (received) @ this time. 3/18/13 at 6:00 a.m., received PRN nitro (nitroglycerin) @ 548 a (5:45 a.m.) (symbol for with) (symbol for no) relief. Rec 2nd dose @ 5:56 a.m., C/O (complaint of) pain (arrow up) 911 called for transport to (local hospital) ER (emergency room) ...6:10 a.m. Rec. dose #3 @ 601 a (6:01 a.m.) C/O chest pain cont (continues) ...in bed with (arrow up) anxiety @ this time. Went out of room preparing for transport. 615 a (6:15 a.m.) returned to res room, res noted (symbol for with) (symbol for no) pulse, (symbol for no) respirations. Skin W/D (warm/dry). 620a (6:20 a.m.) call placed to daughter to notified (sic) of death. 7am MD notified of res death (symbol for with) order to release body to funeral home."</p> <p>A form titled "Resident Transfer"</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated, "...Date of Transfer: 3/18/13...Condition/Reason for Transfer: C/O (complaint of) chest pain NTG (nitroglycerin) given 5:48 AM, 5:56 AM & 6:01 AM,...Resuscitation status...(a box was marked to indicate) Full Resuscitation...."</p> <p>Two care plans were located in the chart regarding the resident's code status. The first was dated 3/8/13, and indicated "Problem/Need: Code status, full code; Goal/Target Date: Wishes will be honored QD (every day) -TNR (unknown abbreviation); Approaches: Notify MD and family of any changes in condition, Wishes will be honored."</p> <p>The second care plan, dated 3/12/13, indicated "Problem/Need: Code Status-Full Code; Goal/Target Date: Wishes will be honored QD-TNR; Approaches; Notify MD & family of any changes in condition, wishes will be honored."</p> <p>A policy and procedure was received on March 22, 2013 at 10:30 a.m. from the Administrator, as the current policy, titled "Cardio-Pulmonary Resuscitation (CPR)." The policy indicated, "Guideline: It is the intent of the facility to ensure that all residents suffering a cardiac or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>respiratory arrest will receive the treatment of CPR unless the resident has a Do Not Resuscitate order...Responsibility:...2. Residents request FULL CODE STATUS will receive CPR if they arrest...Procedure: 1. Check chart for code status. 2. Assess resident to determine if respirations have ceased...3. If a resident who wishes to be resuscitated appears to be having an arrest, the licensed nurse will assess the resident for absence of heartbeat using a stethoscope or palpate pulses and assess for absence of respirations. Call for assistance. 4. If the resident has a cessation of heartbeat or a cessation of respiration and if the resident wished to be resuscitated delegate a person to page for assistance, call 911. 5. All available licensed nurses and staff trained in CPR will respond promptly to the Code and assist as needed...10. Maintain basic life support until ambulance arrives to transport to hospital...."</p> <p>Documentation from the EMT run sheet, dated 3-18-13 (no time noted), indicated, "...upon arrival in scene we were pointed to her room, nobody else aside of pt (patient) in room. Pt's eyes open staring non reactive no rise & fall of chest, male nurse had</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>followed us into room...no movement of pt, addressed nurse that pt had been deceased. Nurse stated that she had been alive abt (about) 5 min prior, he went to bedside, checked pulse, no pulse, checked with eyeglasses for breathing (fog glasses) negative, glasses clear, Asked if pt was a DNR, Nurse #1 confirmed passing of Pt. No pt contact."</p> <p>An interview with Nurse #1 on 3/22/13 at 12:28 p.m., indicated he was "called into the resident's room due to chest pain." Vital signs were taken, nitro was provided with no relief, and 911 was called from the desk. "Then I went back into the room for transfer. EMS came into the room; she had passed away. I checked her pulse. The ambulance asked if she was a full code. They said nothing could be started since it was not already started. I should have started it."</p> <p>An interview with Nurse #2 on 3/22/13 at 9:30 a.m., indicated when she came on the day shift, "the night nurse said he was getting ready to send a resident out. I asked if I could help. He said it was not needed that he thought things were covered. I thought things were under control. The EMTs went into the room with the night shift. I know CPR was not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>initiated. The EMTs said there is nothing more they can do."</p> <p>An interview with QMA #1 on 3/22/13 at 12:20 p.m., indicated "I came in early to get papers ready for a hospital visit for Resident #A. The nurse gave the resident nitro; it did not work. The nurse was in the room with the resident and stepped out to call 911. He went back in the room and the resident was gone."</p> <p>An interview with CNA #2 on 3/22/13 at 12:30 p.m. indicated, "I was not there long. I answered the call light. She was having chest pain. I ran out and got the nurse I left 5 minutes later. My shift is over at 6 a.m."</p> <p>An interview with the local ambulance company, on 3/22/13 at 12:45 p.m., indicated, "when we go somewhere and the resident has passed, we do not start CPR unless we are told to."</p> <p>An interview with the Administrator and the ADON (Assistant Director of Nursing) on 3/22/13, indicated, "(Nurse #1) has been on suspension since the incident and will be terminated today (3/22/13), for not meeting professional standards."</p> <p>A Facility Investigation handwritten</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>note, dated 3/18/13 (not timed), signed by Nurse #1, indicated, "...I had been out of the room for two to three minutes to check on status of staff preparing paper work for transfer to hospital and notification about condition and pending transportation. When I started back to her room I saw the ambulance personnel in hall and directed them to the room. On entering the room I noticed resident with no respirations and checked for a pulse and found none. Staff from life squad stated they would not be able to initiate CPR since it hadn't been started before they arrived and resident already had no pulse and no respirations. They asked code status and I said 'I believe she is a full code.'"</p> <p>A Facility Investigation note, dated 3/19/13 (not timed), signed by Nurse #1 indicated, "...Resident had complained about chest pain and received nitro, after administering second dose I called 911 for transportation. I then gave a third dose and checked her vital signs a second time. I left her room to inform the oncoming nurse of her condition and to check and see if paperwork was being prepared and if hospital was notified. I saw the life squad in the hall and directed them to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident's room, I entered the room with the three EMS staff and we noticed she had no respirations. I checked for a pulse and found none. Staff from the ambulance personnel asked what her code status was I answered 'I believe she is a full code.' The oncoming nurse confirmed her status. I expected EMS would initiate CPR assuming they had the necessary equipment with them, and stepped back. They said they 'couldn't' touch her since nothing had been started before they arrived. This led me to the conclusion they would be of no assistance."</p> <p>A Facility Investigation note, dated 3/18/13, signed by CNA #1, indicated "Came into work 3/18/13 5:50 a.m. to copy papers for pt going to go to appt (appointment) @ hosp was @ the desk copying papers when Nurse (#1) came said pt C/O of chest pain gave NTG X3 still C/O came out to call 911-Nurse (#1) called 911 went back into rm (symbol for with) pt came back out said pt expired 911 was in rm told that she was full code."</p> <p>A Facility Investigation note, dated 3/18/13, signed by Nurse #2 indicated "Ambulance arrived @ 615 am (Nurse #1) went to the room and I followed. Resident was already gone. I stated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>'she is gone.' EMT also stated she is gone and there is nothing that can be done. So squad left. I did not state that she was a DNR. Nurse #1 did not state in the room that she was a DNR."</p> <p>A review of an American Heart Association Basic Life Support for Healthcare Providers Course Roster, Date: 4/15/12, for Course: Healthcare provider CPR/AED (automatic external defibrillator), indicated Nurse #1 under course participants, 96% complete.</p> <p>This federal tag relates to complaint IN00126288.</p> <p>3.1-37(a)</p>				