STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUGAR GROVE SENIOR LIVING COMMUNITY	5865 SUGAR LN PLAINFIELD, IN 46168

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00402850 and IN00402509. Complaint IN00402850 - State deficiencies related to the allegations are cited at R0052. Complaint IN00402509 - No deficiencies related to the allegations are cited. Survey date: March 6 and 7, 2023. Facility number: 012394 Residential Census: 109 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 16, 2023.	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure a resident was free from neglect when the staff failed to ensure a thorough assessment of a resident with a change of condition, failed to ensure continued monitoring of and assessment for worsening symptoms, and failed to provide rescue efforts after the resident was noted to have stopped breathing before EMS (emergency medical staff)	R 0052	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and	04/07/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Holly Wachtel	HFA	03/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	arrived which resulted in the resident ultimately dying due to multisystem organ failure and anoxic encephalopathy following cardiac arrest for 1 of 3 residents reviewed for neglect (Resident B). Findings include: During a confidential interview, it was indicated, on the morning of 11/26/22, Resident B experienced an acute medical emergency and was found unresponsive. Staff did nothing to assist her besides call 911. No one attempted to do CPR (cardio-pulmonary resuscitation) even though she was a well-known full code status resident, and her code status was posted inside the resident's apartment bathroom. Resident B was sent to the hospital where she later died from anoxic brain injury secondary to cardiac arrest and had multi-system organ failure. The Charge Nurse did not complete a full assessment and left the struggling resident with an unqualified personnel. During a confidential interview during the survey, it was indicated staff has last seen Resident B, at her normal baseline-self earlier that morning of 11/26/22. Nursing staff had been giving/receiving report, and while doing so, had carried on personal conversations, laughed and were perhaps too loud. Resident B opened her apartment door and indicated, "Hey, is everything ok out there?" Nursing staff assured her it was and resumed report. Nursing staff indicated, Resident B took her morning medications around 8:00 a.m., without issues, appeared well, and had no complaints or concerns. During a confidential interview during the survey, it was indicated nursing staff knocked on Resident B's door to deliver her breakfast room tray. Resident B did not answer, so the staff		submitted solely because of requirements under state and federal laws. Alleged Deficiency: Facility failed to ensure that a resident was free from neglect when the staff failed to ensure a thorough assessment of a resident with a change of condition, failed to ensure continued monitoring of and assessment for worsening symptoms, and failed to provide rescue efforts after the resident was noted to have stopped breathing before EMS arrived. **Corrective actions for the resident cited:** Resident no longer resides at the community. **Other residents that have the potential to be affected by the deficiency:** All residents that present with a change of condition have the potential to be affected by the alleged deficient practice. **Measures or systems put in to place to ensure that the deficiency does not reoccur:** · ED\Designee to provide all staff re-education on Abuse & Neglect Policy by 3/30/2023 . · An audit to ensure that all Assisted Living & Memory Care residents have a copy of their Advanced Directives posted in their apartment will be completed by DON or designee. · DON\Designee to	

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	entered the room. The room was a little dark, but the staff could see Resident B was sitting on her, "long char" [couch], but she was leaned over to the side. When the staff called Resident B's name, she did not answer. Resident B was "mouthing," her mouth was moving but nothing came out. Staff ran immediately to get the nurse. During an interview on 3/6/23 at 12:25 p.m., Qualified Medication Aide (QMA) 9 indicated a Certified Nursing Assistant (CNA) informed him something was wrong with Resident B. QMA 9 was closest to Resident B's room and immediately went to see what was wrong. Upon entrance to her apartment, QMA 9 indicated Resident B was laying on her couch and did not respond verbally but was noted to be breathing at that time. He called for the nurse because as a QMA, he was not qualified to conduct nursing assessments. QMA 9 attempted to get Resident B's vital signs by using a portable blood pressure cuff, and portable finger pulse/oxygen oximeter (pulse/ox- a medical device used to detect pulse and blood oxygen saturation levels). He was unable to get vitals, as the pulse/ox device did not register any reading. He tried a second pulse/ox which belonged to the resident, but it also did not register a pulse or oxygen saturation level. When asked if the QMA placed his fingers on Resident B's wrist to check for a radial pulse, he indicated, "no." When asked if he attempted to check Resident B's neck for a carotid artery pulse, he indicated, "no." QMA 9 indicated the nurse came quickly and directed him to stay with Resident B and to continue trying to get her vital signs. The nurse left the room to go check her chart and call 911. QMA 9 did not recall what her vital signs were, where he wrote them down, or where they were charted.		re-educate clinical staff on policy for Advanced Directives which includes the location of code status in resident apartments by 3/30/2023. · DON\Designee to re-educate clinical staff on the change of condition process & documentation by 3/30/2023. · ED/DON/Designee to provide all staff training on emergency response by 3/30/2023. · An audit of CPR certification for clinical staff will be completed by Business Office Manager\Designee by 3/30/2023. On-going audits will be completed quarterly. · DON\Designee provided 1:1 education on Abuse & Neglect Policy, Advanced Directives, Change of Condition process & Documentation, and Emergency Response to QMA on 3/24/23. DON\Designee provided 1:1 education on Abuse & Neglect Policy, Advanced Directives, Change of Condition process & Documentation, and Emergency Response to LPN on 3/25/23. **Ongoing monitoring to ensure compliance** · DON or designee will audit placement of advanced directives for new residents within 24 hours of move in. Any discrepancies will be immediately addressed &	

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	During an interview on 3/6/23 at 11:28 a.m., Licensed Practical Nurse (LPN) 10 indicated she was the nurse on duty the morning of 11/26/22. At the time of the incident, she had been on the hall passing morning medications when a CNA came and told her something was wrong with Resident B, "she's not responding." The nurse and the CNA immediately went to the resident's apartment. Upon entrance, LPN 10 indicated Resident B was lying flat on her couch and LPN 10 instructed the QMA who was with her to turn her a little to her side in case she was having a seizure. The QMA, who was with Resident, was trying to get vital signs but indicated he could not get an oxygen saturation level. LPN 10 touched the resident's fingers and indicated they were "cool to the touch," so she directed the QMA to warm her fingers and try the pulse oximeter again. LPN 10 indicated Resident B's eyes were open but stared off blankly and she exhibited pursed-lip breathing. LPN 10 indicated the QMA had a piece of paper with a set of vital signs written down which LPN 10 looked at and determined the vital signs were "within normal limits." She did not recall what they were or if they were officially charted. Because the resident was still breathing at that time, LPN 10 indicated she felt comfortable leaving the QMA alone with the resident so she could call 911. LPN 10 indicated she left the room to go to the nurse's station, located Resident B's hard chart, flipped through the chart to confirm the resident's full code status, called 911, called both resident's daughters and begun making copies of the necessary paperwork which would be needed by the EMS staff before she attempted to return to the resident. She was still at the nurse's station when EMS arrived. When asked if there were additional ways to check for a pulse or oxygen saturation level, LPN		brought to ED. This will be an on-going audit with results being reviewed during QAPI. · Monthly audits of Advanced Directives for all Assisted Living & Memory Care residents will be on-going by DON. Discrepancies will be immediately addressed & brought to the ED. Results will be reviewed during QAPI. · Audits to confirm CPR certification will be conducted quarterly by Business Office Manager\Designee. · DON or designee to conduct Mock Codes once a month for each shift times one month then quarterly thereafter. Results will be reviewed in QAPI. · DON or designee will question 2 random clinical staff members on how to assess for a pulse. Staff members should be from 2 different shifts & this will be done three times a week x's 4 weeks. Results will be shared at QAPI & committee will determine stop date. Immediate re-education will be provided as needed. · Crash carts will be audited daily & re-stocked as needed. Audit results will be brought to stand up daily & maintained in the EDs office. Completion Date: April 7, 2023	

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	10 indicated an oximeter could be placed on the ear lobe or even a toe, but in the moment of the emergency, she had not done that or directed the QMA to do that because her initial thought was perhaps Resident B had experienced a seizure. LPN 10 indicated she remembered touching the resident's fingers which were cool but did not check her pulse at the wrist or neck. When asked what the indication of a low or no reading on the pulse/ox meant, LPN 10 indicated, "a low reading can also mean little to no circulation or possible less circulation through the body." During an interview on 3/6/23 at 3:11 p.m., the Director of Nursing (DON) indicated there was no Automated External Defibrillator (AED - a medical device designed to analyze the heart rhythm and deliver an electric shock to victims of ventricular fibrillation to restore the heart rhythm to normal) device in the building, and there was no supplemental oxygen available. Although the facility did have a Crash-Cart, there was only a limited variety of supplies, which included items such as oxygen tubing, PPE (personal protective equipment) and an ambu bag (automated artificial manual breathing units). When asked what the nursing expectations for the responding staff were at the time of the incident the DON indicated, a QMA could not perform a nursing assessment, so his responsibility was to get the nurse, which he did. The LPN should assess the situation, she should attempt to call her name, shake her, do a sternal rub and if that did not work check for breathing by rise and fall of her chest and check her pulse. In an emergency it was acceptable for the nurse to leave to call 911 or have someone else go call 911. The DON indicated, LPN 10 would not have needed to leave the resident's room to confirm her code status, because shortly after the DON started in September of 2022, she			

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	implemented a new facility-wide policy/procedure by posting each resident's code status inside their apartment bathroom, for faster easier access for staff to find. On 3/6/23 at 3:13 p.m., Resident G was observed in her apartment. At that time, she indicated her code status was posted in her bathroom under the sink and opened the cabinet door to reveal her posted full-code status. On 3/6/23 at 3:20 p.m., Resident H was observed in her apartment. At that time, she indicated her code status was posted under her bathroom sink and opened the cabinet to reveal her current and correct DNR (do not resuscitate) form. On 3/6/23 at 3:25 p.m., Resident K was observed in her apartment. At that time, she indicated her code status was posted in her bathroom under the sink and opened the cabinet to reveal a current DNR form. During an interview, on 3/6/23 at 2:57 p.m., the Registered Occupational Therapist (OTR) indicated he was CPR certified. When asked, in the case of an emergency, what would he do if he observed a resident who was found to be unresponsive; the OTR indicated, he would first call for nurse back up and assistance, then 911, then check for an open airway and a pulse of the carotid artery. If there was no pulse, he would start BLS (basic life support) CPR of 30 compressions and 2 breaths repeatedly. The OTR indicate he would not leave an unresponsive resident alone with a QMA or a Certified Nursing Aide (CNA). If a pulse oximeter was being used and did not register a pulse or oxygen level, and no pulse could be felt at the person's neck, then CPR should be initiated.			

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	During an interview, on 3/6/23 at 3:27 p.m., LPN 8 indicated the facility did not have an AED machine because they were only an Assisted Living facility. When asked, in the case of an emergency, what would she do if she found an unresponsive resident; LPN 8 indicated she would have checked for breathing and a pulse. Options for checking for a pulse could have been on the neck, wrist, and she could use an oxygen oximeter on the earlobe if needed. When using a pulse oximeter if the reading was blank, or did not register, that would mean the resident had no pulse so she would immediately check the code status posted under the sink in the resident's bathroom. If the resident was a full code status, she would ensure there was no pulse by checking the wrist or neck, and initiated compressions as needed. She would call for back up and someone else to call 911 or get the crash cart if needed. During an interview on 3/7/23 at 12:50 p.m., the Plainfield Fire & Rescue EMS Captain indicated he and an EMS team responded to the 911 call for Resident B on the morning of 11/26/22. Upon entrance to the building, the team was not met at the front entrance, but approached halfway down the hallway by an unidentified female staff member who told them Resident B had stopped breathing. EMS picked up their pace and rushed faster to her room. Upon entrance to her room, the Captain recalled being surprised that the patient was still seated on the couch, her feet on the floor and her head "slumped" over to the left side of her couch. There was a male staff person in the room, who stood to the right of the resident but was not performing any tasks. The Captain indicated since EMS staff had already been told on their way to the room that the resident had stopped breathing and she was a full code, so			

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	they would have expected to see staff at least initiated rescue breaths or placing the person in a rescue position or attempting to initiate CPR. The Captain indicated the staff member who was next to the resident only stood beside her, his hand on her shoulder, and "looked bewildered, like he didn't know what to do." Two of the crew members immediately transferred her from the couch to the floor and the Captain was the first to person to initiate CPR until the Lucas device (mechanical chest compression device) could be applied. Although the EMS crew was able to get return of spontaneous circulation (ROSC- the resumption of sustained perfusing cardiac activity associated with significant respiratory effort after cardiac arrest), it was well past the 20-minute mark and she was transferred without delay to the closest hospital. On 3/7/23 at 10:39 a.m., the Plainfield Fire Territory, Fire Chief, provided a copy of the recorded 911 dispatch call which was received on the morning of 11/26/22 at 9:14 a.m. LPN 10 indicated, " ...we have someone who is not responding ..." The 911 dispatcher asked what a good phone number for the nurse was, and LPN 10 did not know the facility number, so the dispatcher read off the caller ID which LPN 10 indicated was the number to the front desk, "I don't know the direct number to this phone." The dispatcher asked the nurse if she was with the patient at that time, and LPN 10 indicated, "no, I have the Q [QMA] with her, I'm in the office." The dispatcher asked for additional details, "is she awake?" LPN 10 answered, "no, she's not responding, she's purse-lipped breathing ... she's pale, and cool to touch." The dispatcher confirmed LPN 10 was the charge nurse and had visualized the patient. LPN 10 answered, "yes, I have the Q getting vitals on her right now, we			

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	haven't gotten the vitals yet, they are in the process of getting them." The dispatcher asked if additional medication or equipment would be needed and LPN 10 indicated, "no," but informed the dispatcher that the resident was a full code. A corresponding EMS Run Report, dated 11/26/22, was provided on 3/6/22 at 1:49 p.m., by a Plainfield Fire Territory Executive Assistant. The Run report indicated, "dispatched and responded, 911, with lights and sirens to Sugar Grove Senior Living [Resident B's apartment number] on a sick person ... As EMS was on the way to the patient's room, staff reported the pt [patient]was now, not breathing ... arrived to find a [70-year-old white female] slumped over on her [right] side, on her living room couch. [Patient] unresponsive, not breathing, pulseless... moved to the floor via carry x 2 and placed supine. CPR initiated ... Staff x1 in the room not performing any tasks ...." The Run Report indicated the patient suffered cardiac arrest before EMT arrival. At the first assessment the patient was: unresponsive, cyanotic (bluish or grayish color of the skin, nails, lips, or around the eyes), pale, both pupils were dilated at 5 mm (millimeters) and non-reactive and pulse was absent. The estimated time of arrest was 10-15 minutes, estimated time of collapse to 911 was 10 minutes, and the estimated time of collapse to CPR was 5 minutes. The first attempt at CPR was started at 9:21 a.m. and continued until 9:46 a.m. when ROSC was achieved. The patient received 5 doses of epinephrine. On 3/6/23 at 10:26 a.m., Resident B's medical record was reviewed. She was an Assisted Living resident who had resided in the facility since 2018. Her current Code Status wishes were recorded upon admission on 9/28/2018. The Code Status			

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	was checked for full code and indicated, "It shall be the general policy of Sugar Grove Senior Living to provide care to its residents to restore health, sustain life and ease suffering in conformity with ethical standards, medical standards and the requirements of the law ... Full Code, Full Resuscitation: Medical procedure to restart breathing or heart functioning will be instructed (CPR). Immediate transfer to hospital ...." On 6/20/2020 Resident B had a follow up with her primary care physician and the following was noted, "[patient] was hospitalized on 5/15 - 5/24/2020 for swelling, found to have AKI, new onset CHF and a hgb [hemoglobin] of 7.8 (down from ~13 in January 2020) ... AKI had resolved at time of d/c [discharge]. She was found to have EF 30-40% and was started on coreg, aldacrone 12.5, and losartan. Patient was discharged back to Sugar Grove ... [Resident B] went back to the hospital 5/31/2020 for hypotension and generalized weakness, again found to have AKI and mild pulm [pulmonary] edema, she discharged back to the facility ...She has also been sent to IU ER once for seizures per Sugar Grove report ... Assessment and Plan: Diagnoses and all orders for this visit ... [included, but not limited to] Partial idiopathic epilepsy with seizure of localized onset, not intractable, without status epilepticus (chronic) and chronic systolic congestive heart failure. Resident B was sent back to the AL with patient education and instructions titled, "Chest Discomfort/Heart Attack Zone." An After Visit Hospital Summary, dated 5/31/22, indicated Resident B had returned to the ED for generalized weakness and CHF. She was discharged back to the AL with education material and instructions related to Heart Failure.			

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	The record lacked documentation of a congruent/comprehensive list of active diagnoses, but her most recent Physician's Order set indicated she had diagnoses which included, but were not limited to, seizures, vascular dementia and chronic back pain. She had current physician's orders to check her weight, blood pressure and heart rate weekly. A review of her November MAR and corresponding November Routine Vital Signs Tracker revealed her vitals had not been recorded for the week of 11/21/22. The most recent service plan was dated 6/23/22. The service plan indicated some of Resident B pertinent diagnoses/conditions: seizure disorder, pain, hypotension (low blood pressure), loss of vision and limited physical mobility- the service plan lacked revision or updated to include anything related to her CHF diagnosis and condition. Resident B's nursing progress from the day of the incident on 11/26/22 were reviewed: At 9:13 a.m., "CNA reported to nurse the resident was unresponsive in her room. Nurse approached resident and noticed she was pursed lip breathing, skin pale, cool to touch, gasping. Nurse exited the room copied the chart...saw she was full code. Nurse made copies of chart." At 9:18 a.m., [changed to 9:13 a.m.] "911 contacted a brief report given." At 9:29 a.m., [changed to 9:20 a.m.] "Residents daughter both contacted and given brief report. Daughters are in route to [hospital]." At 9:21 a.m., "emergency rehydration and CPR initiated." At 9:26 a.m., "[name of nurse] on call contacted given brief report."			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	At 9:50 a.m., "emergency response [continued] with resident." At 11:15 a.m., "nurse contacted resident daughter [name] per her request and gave full report of incident." The record lacked documentation of a full resident assessment and/or documentation of the set of vitals alleged to have been recorded by the QMA. A corresponding witness statement, dated, 11/30/22 indicated, "[LPN 10] was the Charge Nurse on Assisted Living on 11/26/22. It was reported to me that [Resident B] received her prescribed medications at approximately 8:00 a.m. and no complaints were voiced at that time and there was notably nothing out of the ordinary at that time. At the time that the CNA delivered her breakfast meal that she ordered, the CNA observed that she was lying on her couch on her left side and would not verbally respond. The CNA immediately [called] for the attention of [name of the QMA] where he assessed that she was breathing but not responding. I was then immediately sought out as I was on the 100 hallway delivering medications. I immediately went to [Resident B's] room where she was observed to be lying on her side, breathing, with pulse, and verbally unresponsive. [QMA] remained in the room with [Resident B], vitals were initiated ...." LPN 10's witness statement and resident's record lacked documentation that vitals had been obtained or recorded. A corresponding witness statement, dated, 11/30/22 indicated, "At approximately 8:00 a.m., on 11/26/22, [Resident B] came to her doorway per usual and asked for her medications. Her			

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		A. BUILDING 00 B. WING	03/07/2023

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	medications were then given to her where she took them at that time. She spoke briefly to me as she usually did. Did not have any complaints at that time. When a staff member (CNA) went into her room to deliver her breakfast meal that she ordered, it was observed that she was lying on her side on her couch and she was not verbally responding. CNA immediately got my attention, and I went into room to assess. Upon my assessment, [Resident B] was breathing but she was not verbally responding. The nurse was immediately summoned to room where she also assessed [Resident B] and at that time she exited room to call 911, vitals were being initiated, [Resident B] continued breathing. I stayed with [Resident B] the entire time, until EMS came into room where they took over care ...." QMA 9's witness statement and resident's record lacked documentation that vitals had been obtained or recorded. The record lacked documentation the physician was notified. An Emergency Department Hospital Summary, dated 11/26/23 at 10:48 a.m., indicated Resident B presented to the ED from assisted her assisted living facility where, " ...she was found down, pulseless, and in cardiac arrest. EMS reported her last known well was 40 minutes prior to being found, EMS found the patient to be in asystole on cardiac monitor, ACLS was initiated, and she required 4 rounds of epinephrine, intubation and ACLS persisted for 30 to 40 minutes and ROSC was achieved ... Due to the patient severe acidosis [respiratory acidosis develops when there is too much carbon dioxide [an acid] in the body], she was provided with [Sodium bicarbonate- to offset her acidosis], she also required peripheral			

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	pressors and sedation medications. She was found to be COVID-positive ... a long discussion was held with patient's family about critical disposition of the patient ...Experienced prolonged cardiac arrest. She lives in assisted living facility and had not been feeling well recently. She was found by workers in her facility without a pulse. Per chart review, she received CPR for 30+ minutes ... Prognosis for meaningful neurological recovery is poor given the prolonged duration of her cardiac arrest, evidence of multiorgan hypoperfusion injury, seizures on EEG, and very concerning neurological exam ... the patient's family decided to withdraw care. Withdrawal and comfort medications were ordered ...When family decided they were ready the patient's EET [endotracheal tube- intubation] was removed at 3:32 p.m., and patient went into PEA [pulseless electrical activity] at 3:49 p.m., when time of death was called ...." Resident B's Death Certificate, dated 11/30/23, indicated the primary cause of her death was, "multisystem organ failure and anoxic encephalopathy following cardiac arrest." During a follow up interview on 3/7/23 at 10:40 a.m., LPN 10 indicated, she was unaware Resident B had a diagnosis of congestive heart failure (CHF). If she had known Resident B had congestive heart failure, it could have changed her approach to the emergency assessment and she would have looked for additional symptoms such as sudden edema/swelling, discoloration, capillary refill, and to check her lungs for shortness of breath, and/or sounds for fluid on the lungs. New diagnoses were usually added to the chart when the Nurse Practitioner came for regular visits and were also listed on the Physician Order Flow sheets, or Resident's Face			

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	sheet. During an interview on 3/7/23 at 11:17 a.m., the DON indicated, the purpose of a service plan in Assisted Living is general and minimalistic, a basic outline of tasks/services the facility should provide to the resident. For clinical indication, the Functional Assessment was more of a determining screen of the resident's functional level. For resident's who saw an outside provider, (which Resident B did) the facility did not keep an up to date, running list of active/current diagnoses. It would be up to the provider to send over pertinent diagnosis and/or mediations/treatments related to it. If a new diagnosis was listed on a hospital discharge summary and came back with the resident, then yes, it would be expected to be updated somewhere in her record. It would be important to have a current list of active diagnoses, specifically considerate of CHF so that the nurses would know to monitor for ongoing new or worsening exacerbation of symptoms. Resident B was an independent smoker who had an apartment with a direct door to the outside to be able to smoke independently, and smoking can cause worsening or exacerbation of CHF symptoms. On 3/7/23 at 10:58 a.m., the DON provided a copy of LPN 10 and QMA 9's Job Responsibility Requirements: Nurses (RN/LPN) "As a member of the interdisciplinary team, the Nurse assumes planning, responsibility, and accountability for resident care of a designated unit or other assigned area for one shift in accordance with Federal and State regulations and community policies, procedures and resident care plans ... Coordinates and performs patient care ... monitors			

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	delivery of care and services throughout shift to ensure needs are met, tasks are completed, including complete and accurate resident documentation ... Ensures compliance on unit with residents rights ... Ususes good judgement to prepare, administer and immediately document medication and treatments as ordered by physicians ...." Certified Medication Aid (QMA): "the primary purpose of your job position is to assist in the administering of medications to residents as ordered by the attending physician under the direction of the attending physician, the nurse supervisor or charge nurse ... administrative functions ... perform administrative requirements such as completing necessary forms, charts, reports etc., and submit these as may be required ... accurately measure, record and report the vital signs of a resident ...." On 3/6/23 at 4:00 p.m., the Administrator, (ADM) provided a copy of current facility policy titled, "Cardiopulmonary Resuscitation," reviewed, 2/2021. The policy indicated, "Personnel have completed training on the initiation of cardiopulmonary Resuscitation (CPR/Basic Life Support (BLS) in victims of sudden cardiac arrest ... 1. Cardiac attest is defined as inadequate cardiac contractions resulting in insufficient blood flow throughout the body (pulselessness). 2. Sudden cardiac arrest (SCA) is a leading cause of death in adults. 3. Victims of cardiac arrest may initially have gasping respirations or may even appear to be having a seizure. Training in BLS includes recognizing the atypical presentation of SCA ... 5. Depending on the underlying cause, the chances of surviving SCA may be increased if CPR is initiated immediately upon collapse ... 7. The goal of early delivery of CPR is to try to			

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	maintain life until the emergency medical response team arrives to deliver advanced life support (ALS) ... 9. If the resident is full code, per the medical record, a staff member that is certified in CPR will initiate CPR ... Emergency Procedure, 1. The facility's procedure for administering CPR shall incorporate the steps covered in the current American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or facility BLS training material ... The basic life support (BLS) sequence of events is referred to as "C-A-D" (chest compressions, airway, and breathing) ... Begin CPR if the adult victim is unresponsive and not breathing normally (ignore occasional gasps) without assessing the victim's pulse ...." On 3/6/23 at 4:00 p.m., the ADM provided a copy of current facility policy titled, "Crash Cart," reviewed, 6/2020. The policy indicated, " ...the facility will maintain a crash cart that is readily accessible at all times with the necessary items to render medical care on an emergent basis ...." On 3/6/23 at 4:00 p.m., the ADM provided a copy of current facility policy titled, "Charting and Documentation," reviewed, 6/2020. The policy indicated, "Chart all pertinent changes in the resident's condition ... Be concise, accurate, and complete and use objective terms ...Significant Change of Condition- see Significant Change Notification policy for additional information ... Procedure: 1. Accidents/Incidents: ... where the accident or incident took place ... date and time ... name of witnesses and their account ... resident's account ... time the physician was notified as well as the time the physician responded ... the date and time family was notified ... the condition of the resident to include vital signs ... disposition of the resident and all pertinent observations ...."			

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	On 3/7/23 at 10:58 a.m., the DON provided a copy of current, but undated facility policy titled, "Significant Condition Change & Notification." The policy indicated, "to ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below ... a significant change in the resident's physical, mental or psychosocial status ... sudden onset of shortness of breath ...significant change in/or unstable vital signs ... seizure activity ...skin discoloration ... change in level of consciousness/sudden lack of responsiveness ... When any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner. Prior to calling the medical practitioner the nurse will complete the SBAR assessment [Situation (a concise statement of the problem), Background (pertinent and brief information related to the situation), Assessment (analysis and considerations of options), Recommendation (action requested/recommended)] ... Documentation: All significant changes will be recorded on the communication board in PCC and in the resident record, charting will include an assessment of the resident's current status as it related to the change in condition ...." This State Residential Finding relates to Complaint IN00402850.			