STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155810	A. BUILDING _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON HEALTH & REHABILITATION	1955 S VERNON ST WABASH, IN 46992

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00218986. This resulted in an Immediate Jeopardy. Complaint IN00222558 - Substantiated. Federal/State deficiency related to the allegations is cited at F155. Survey dates: February 17,and 20, 2017 Facility number: 000274 Provider number: 155810 AIM number: 100271660 Census bed type: SNF/NF: 81 Total: 81 Census payor type: Medicare: 4 Medicaid: 74 Other: 3 Total: 81 Sample: 5 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on February 22, 2017.	F 000		
F 155 SS=K	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 155		

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

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formulate an advance directive.

c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) 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 resident's option, formulate an advance directive.

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.

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F 155	Continued From page 2 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) to a resident who quested a full code status and was found unresponsive without respirations or a heart beat. This deficient practice affected 1 of 3 residents reviewed who requested CPR and had the potential to affect 45 of 81 residents in the facility who were considered a full code status and would require CPR. The immediate jeopardy began on 2/7/2017 when the facility staff failed to initiate CPR to a full code resident found unresponsive without respirations and pulse. The Administrator was notified of the immediate jeopardy on 2/17/2017 at 1:18 p.m. The immediate jeopardy was removed and the deficient practice corrected, on 2/16/2017, prior to the start of the survey and was therefore Past Noncompliance. Findings include: Resident #B's record was reviewed on 2/17/2017 at 10:30 a.m. Diagnoses included, but were not limited to, traumatic brain injury, epilepsy, aphasia, respiratory distress syndrome and	F 155	Past noncompliance: no plan of correction required.	

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tracheotomy.

Review of the clinical record indicated Resident B had a form titled, "Resuscitative and Life Prolonging Procedures," dated 1/10/214, and signed by the resident's legal representatives.

Review of a nursing progress note, dated 1/15/2015, indicated Resident B was a full code and status had been verified on the face sheet and physician's re-write order's.

Review of the nursing note, dated 2/7/2017 at 12:25 a.m., indicated Resident B was found unresponsive with no pulse. The nursing note lacked any indication CPR had been initiated.

Review of the physician orders indicated Resident B had a physician's order for full code status dated 8/26/2016.

Review of a care plan, dated 4/4/2016, titled "Communication" indicated the resident was nonverbal and could not make his needs or wants known. The resident was unable to answer yes/no questions and relied on staff to provide anticipatory care. Interventions included, but were not limited to, "staff will ensure that I am having my needs met."

Review of a care plan dated 2/19/2016 titled "Code Status" indicated Resident B's parents would make his life decisions and he was a full code. Interventions included, but were not limited to, staff would ensure that Resident B's parents wishes were to be honored.

Review of the facility investigation indicated the following:

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CNA #1 indicated she last saw Resident B between 10:00 p.m. and 10:15 p.m. Resident B had shown no signs of distress.

CNA #2 indicated she was making her rounds around midnight and got to Resident B's room. She noted his color did not look right and called for the nurse.

LPN #3's written statement was as follows: "I was in another residents room and [name of CNA #2] came and got me. We walked into [Resident B's name] room he was pale. I checked his respirations and felt that he was cold. Got vital machine to check O2 (oxygen). It wouldn't read. While I was doing this [name of CNA #2] went to get [name of LPN #4]. [name of LPN #4] came in and asked if I checked his O2 and said check his heart rate. I went to get stethocope [sic]. I came back and check [sic] heart rate with stethoscope [sic] and didn't hear one. [name of LPN #4] checked with my stethocope [sic]. [name of LPN #4] said we need [sic] to call doctor, DON (Director of Nursing), ED (Executive Director) and family. The last time I saw [name of Resident B] was during med pass 5:30-9:30 p.m. [name of Resident B] seemed fine then. [name of LPN #4] nor I went to check to look at code status." LPN #3 later added she did not check the code status because the resident had been dead a while and he was cold.

LPN #4's written statement indicated she was called to Resident B's room. "I walked into the room [name of LPN #3] was there at bedside [sic]. I asked what happened [name of LPN #3] said [name of CNA #2] found him like this. I told her to check for heart rate [sic]. [name of LPN

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#3] checked said she didn't hear a heartbeat. [name of LPN #3] asked what all do I do now. I told her to call DON, ED, family and doctor and funeral home. I went to desk and made [name of LPN #3] a list of things to do. I did not check code status. I did not check because I thought [name of LPN #3] already did. I did not attempt CPR because [name of LPN #3] didn't seem emergent. I thought code status was already checked and [name of Resident B] was a DNR (Do Not Resuscitate) code status. It has not been my practice to check another nurse's patients code status."

During an interview on 2/17/2017 at 11:31 a.m., the DON indicated she and the ADON (Assistant Director of Nursing) read all the nursing progress notes to review care. She indicated she had been behind in the reading of the nursing notes and did not read about the 2/7/2017 incident until 2/15/2017. She indicated she questioned LPN #3 regarding her actions during the incident and asked if she had initiated CPR. She stated LPN #3 did not initiate CPR for Resident B. "Second and third shift do a walking report at 11:00 p.m. and the first round bed check has to be done by 1:00 a.m. CNA #2 said she found him at midnight." The DON indicated resident code status are indicated by a colored banner on the electronic chart: green for full code and red for DNR.

Review of a memorandum from the corporate Regional Director of Clinical Services, dated 3/4/2016, indicated the following:

"... The essential message is that in our environment, it is all or nothing. Even if a resident is found pulseless and breathless with

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rigor, CPR must be initiated if the code status is full code. At no time is a nurse at liberty to make a judgement call and not do CPR. EMS will make that determination when they arrive. ... Staff must clearly know where to find a resident's code status in Matrix [computer based documentation system] and respond accordingly." LPN #3 and LPN #4's signature on an inservice sign in sheet dated 3/7/2016 indicated both nurses had read and understood the policy.

Review of a current policy, dated 4/7/2014, titled "Cardiopulmonary Resuscitation (CPR) Do Not Initiate Cardiopulmonary Resuscitation (DNR) Informed Consent" indicated the following:
"Purpose: To support and provide the right for each resident to formulate a resuscitation advance directive.
Procedure:
1. Social Services Director/designee and \or Licensed Nurse will review resuscitation options and document self determination preferences from the resident or the legal representative. (Utilize INTERACT resource tool for Education on CPR for Residents and Families)
2. Resuscitation options will be a Full Code (CPR) or Do Not Resuscitate.
3. Review will include that the facility will provide basic life support, including
initiation of CPR, to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with that resident's advance directives or in the absence of advance directives or a DNR order.
4. The decision for Full Code (CPR) or DNR will be documented in the medical record.
5. A physician order will reflect the resuscitation status.
6. If a resident or legal representative wishes to

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change their resuscitation status, the discussion should be documented in the medical record and physician order update.
7. State specific regulations will be followed as applicable.
Staff should initiate CPR when cardiac arrest occurs on:
1)residents [sic] who have requested CPR
2)residents [sic] who have not formulated an advance directive ..."

The past noncompliance immediate jeopardy began on 2/7/2017. The immediate jeopardy was removed and the deficient practice corrected by February 16, 2017 after the facility implemented a systemic plan that included the following actions: provided education for all nurses on CPR guidelines and expectations and location of the code status in the medical record, reviewed the code status for all residents and validated the CPR certification of all nursing staff.

This Federal tag relates to Complaint IN00222558

3.1-27(a)(3)