DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00366741. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00366741 - Substantiated. Federal/State deficiencies related to the allegations are cited at F678 Survey dates: November 10, 11, and 12, 2021 Facility number: 010996 Provider number: 155665 AIM number: 200232210 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 9 Medicaid: 71 Other: 23 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 16, 2021.	F 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **The provider alleges compliance as of 11-12-2021** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	
F 0678 SS=J Bldg. 00	483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the			

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

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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	arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. Based on interview, observation, and record review, the facility failed to provide emergency basic life support of rescue breathing, immediately when needed, for a resident after staff witnessed the resident go unresponsive with no breathing and failed to have the necessary equipment available for staff to perform rescue breathing. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 11/4/21 at 1:50 p.m. While staff members were providing Resident B with a bed bath, the resident became unresponsive with no breathing. Staff members went to provide CPR (a medical intervention used to restore circulatory and respiratory function that has ceased), and neither of the two facility crash carts had an Adult Bag Valve Mask (BVM) or face shield. During the code no breaths were provided to the resident. Staff placed the resident's nasal canula on his nose with supplemental oxygen. The resident was provided only chest compressions until EMS arrived. The resident's full code status was signed by the physician on 10/28/21. The resident expired on 11/4/21 at 2:16 p.m. Findings include: A record review for Resident B on 11/10/21 at 11:08 a.m., indicated the resident was cognitively intact, required two physical staff members' extensive assistance for mobility, he was totally dependent for transfer, and required one physical staff member's extensive assistance for ADLs (Activities of Daily Living).	F 0678	**F 678: Cardio-Pulmonary Resuscitation (CPR)** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1. Resident(s) B was identified during the time of observation. All care team members have been educated on cardio-pulmonary resuscitation on , crash cart check list/location, and necessary equipment.2. Education was provided on 11/17/21 and 11/18/21 and in alignment with the American Health Association (BLS for Healthcare providers) via Instructor LaRena Steinhaus, Regional Nurse Consultant. Training course materials can be found directly on American Heart Association CPR & First Aid 3. Education was in the form of classroom setting and in 4 hour training sections. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All Residents have the potential to be affected by this practice.2. A campus wide review was completed to review all Residents with full code status. Campus provided Code training and onsite CPR certification/license renewal	11/18/2021

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	A Care Plan, dated 3/12/21, indicated Resident B had established advanced directive and wished to be a Full Code. Interventions included but were not limited to refer to Physician Orders for Scope of Treatment. A physician's order, dated 10/28/21, indicated the resident's code status was a full code. A progress note, dated 11/4/21 at 1:50 p.m., indicated the nurse was notified Resident B was not breathing and had no pulse. CPR (Cardiopulmonary Resuscitation) was initiated, and AED (automated external defibrillator) pads were placed on the resident. 911 was called. Facility staff continued rescue efforts until EMS (Emergency Medical Services) arrived. The AED advised no shock times two, and to continue CPR. EMS team took over rescue efforts. EMS notified the doctor of status and code called, and the time of death was 2:16 p.m. The EMS report, dated 11/4/21 at 4:35 p.m., indicated EMS arrived at the facility at 2:05 p.m. and was directed to Resident B's room. Upon entering the room, the facility staff requested an BVM from the EMS staff and was provided one from the EMS equipment bag. Facility staff members indicated no shocks were given prior to EMS arrival, and EMS took over the code. EMS received a CPR cease order, and the resident was pronounced deceased. During an observation and interview, on 11/10/21 at 10:07 a.m., QMA (Qualified Medication Assistant) 2 was observed sitting at the D Hall nurses' station. She indicated the crash cart was behind her. The cart was observed. The cart had no cover, and there was a large purse and		on 11/17/21 and 11/18/21. Inventory audits have been completed and resupplied as needed. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure crash carts are supplied and stocked with appropriate equipment per policy. The plan will be revised, as warranted. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.1. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff.2. Daily crash cart audits will remain in effect indefinitely. QA monitoring will discontinue when all audits have yielded 100% compliance x6 months consecutively has been achieved. 3. All employee CPR certifications to be reviewed on monthly QA basis. QA monitoring to discontinue when 100% compliance x6 months consecutively has been achieved. 4. Findings will be reported at	

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	sweatshirt on top of the supplies. She provided a blank copy of the Night Shift Crash Cart Audit check list. The last audit completed for the cart was dated 8/1/21. The items not located on the cart were the following: Clip board with Code Blue documentation, Adult BVM with Mask and Tubing, CPR rescue mask with valve, disposable gowns, non-rebreather mask, oxygen mask, bandage scissors, blood pressure cuff and stethoscope, 4 by 4 gauze sponges, adhesive and surgical tape. The AED was not on the cart. She indicated there was a code over the weekend; the AED was being serviced and pads had been ordered on Monday. During an observation and interview, on 11/10/21 at 10:12 a.m., RN 3 indicated the A Hall crash cart was covered with a blue blanket. She provided a blank copy of the Night Shift Crash Cart Audit check list for the A Hall. The last audit was dated 8/1/21. The items not located on the cart were the following: Clip board with Code Blue documentation, extension cord, face shield, non-rebreather mask, and no AED. She indicated the AED was on the wall next to the main office. There was no AED observed on the wall next to the main office. During an interview on 11/10/21 at 10:20 a.m., the Unit Manager indicated the AED was in the DON's (Director of Nursing) office and a new one had been ordered. During an interview on 11/10/21 at 12:15 p.m., the EMS EMT (Emergency Medical Technician) indicated upon arrival at the facility, they were directed to Resident B's room. The EMT indicated a large male was observed lying on the bed next to the window. There was a crash cart in the room; but there was no suction and no BVM. A staff		the QA meeting monthly or until substantial compliance has been determined.	

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	member was standing at the head of the bed, on the window side, she asked us for a BVM, so one was provided from the EMS bag. There was a staff member doing compressions, there were no rescue breaths being given until EMS arrived and took over the CPR. The paramedic received cease orders and the resident was pronounced deceased. The MT indicated EMS gave rescue breaths with a BVM out of their equipment during the code. During an interview on 11/10/21 at 2:05 p.m., RN 3 indicated it was around 2:00 p.m., she was out getting lunch, when she received a call concerning the Code Blue. She instructed the caller to notify someone in the building. She immediately returned to the building and staff were in Resident B's room, when she entered the room, he was lying in his bed next to the window, the ADON and DON were doing compressions. She cleared the hall of residents, staff, and equipment and went to assist the unit manager. She had sent Resident B out the day before due to critical hemoglobin and thematic labs. She did not see any rescue breathing while she was in the room, she had asked if they needed oxygen and the ADON said, "no Abu bag [BVM]." She did not see a mouth shield and did not observe any rescue breathing. During an interview on 11/10/21 at 2:20 p.m., CNA 8 indicated when the code occurred on 11/4/21, the nurse on the A Hall and the QMA on the C Hall were gone to lunch. She went to the room and ask if the staff present needed anything. They sent her to look for the BVM, but she couldn't find one. During an interview on 11/10/21 at 2:26 p.m., QMA 9 indicated she had been working on the B Hall			

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when they saw the management staff running down toward the C Hall. She went to assist and upon entry observed the resident lying on his bed, the privacy curtain was pulled, there was lots of staff in the room, and the crash cart was there, so she got in line to give compressions. She did not do rescue breathing and did not observe anyone doing rescue breathing.

During an interview on 11/10/21 at 2:39 p.m., the Unit Manager indicated she was in a care plan meeting on 11/4/21, so it was several minutes before she arrived at the code. Upon entry to the room, staff were doing compressions. No one was doing rescue breathing because the resident was on oxygen. Normally he was on two litters of oxygen, but the concentrator was on five litters. There was no BVM on the crash cart and a staff member was sent for it. She then went to the nurses' station to make notification phone calls.

During an interview on 11/10/21 at 2:45 p.m., LPN 10 indicated she was working the D Hall on 11/4/21. She indicated the D Hall CNA notified her a nurse was needed "right now" on the C Hall. She heard a commotion as she arrived at Resident B's room and staff were "coding" the resident. One staff was doing compressions. Upon entry to the room, she observed Resident B lying in bed, he was blue, and compressions were being administered. No one was doing rescue breathing, he had a nasal canula, he normally was on two litters of oxygen, but she was not sure of the setting at the time of the code. There were multiple staff in the room, they took turns doing 30 compressions each and then would switch. No rescue breathing, no BVM, and no mouth to mouth was observed. When EMS arrived to the facility, they "worked" on him.

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During an interview on 11/10/21 at 3:13 p.m., the previous ADON indicated she was in her office when she was notified the CNA had been giving Resident B a bath, he coughed and then stopped breathing. She ran to the C Hall and upon entry the crash cart was there. No rescue breaths were being given. She stated, "you can do CPR without rescue breathing." She does not know how many rounds of compressions were completed on the resident. When EMS arrived, she left the room, and the resident was a dusky purplish color.

During an interview on 11/10/21 at 4:07 a.m., the MDS coordinator indicated, on 5/5/21, a CPR class was provided to staff in the building.

During an interview on 11/10/21 at 4:10 p.m., CNA 8 indicated she had looked on both crash carts for an BVM during the code, but she could not find one anywhere.

During an interview on 11/12/21 at 10:00 a.m., CNA 12 indicated on 11/4/21 she and CNA 13 started giving Resident B a bed bath around 1:30 p.m. He was talking to them the whole time, and after the bath and shaving, they had lifted him up in the Hoyer to get his weight. His oxygen tubing was off. CNA 13 read the weight and glanced back a Resident B and he had stopped breathing. That was around 1:45 p.m., CNA 13 ran to notify the nurse and she stayed in the room. She put his oxygen back on him and raised the head of the bed.

During an interview on 11/12/21 at 10:03 a.m., CNA 13 indicated on 11/4/21 she and CNA 12 were giving Resident B a bed bath. He was talking to them the whole time, and after the bath, they had lifted him up in the Hoyer to get his weight. His oxygen tubing was off. CNA 13 read the

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	weight and glanced back a Resident B and he had stopped breathing. She ran to notify the nurse and CNA 12 stayed in the room. The current facility policy "Cardiopulmonary Resuscitation (CPR)" with a revision date of July 2020, was provided by the Regional DON on 11/10/21 at 11:20 a.m. The policy indicated, " ...Policy: The facility must provide basic life support, including CPR, to a resident requiring such emergency care ...Procedure: 1 ...The facility must ensure that team members properly trained in basic lifesaving support ...prior to the arrival of emergency medical services ...Emergency Procedure - Cardiopulmonary Resuscitation ...1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing ...begin CPR: 1. d. initiate the basic life support (BLS) sequence of events ...3. Chest compressions: ...4 Airway: ...clear airway ...5. Breathing: After 30 chest compressions provide 2 breaths via ambu bag [BVM] or manually (with CPR shield) ..." The American Heart Association described the steps for CPR as follows (https://ahainstructornetwork.org/idc/groups/aha ecc-public/@wcm/@ecc/documents/downloadabl e/ucm_506678.pdf 2020). "High-Quality CPR Components for BLS [Basic Life Support Providers]...Adults and adolescents...1 or 2 rescuers... Compression-ventilation ratio without advanced airway... 30 [compressions]: [to] 2 [breaths]...Compression rate 100-120 [compressions a minute]...Compression-ventilation ratio with advanced airway...Continuous compressions at a rate of 100-120/min...give 1 breath every 6 seconds."			

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	The Immediate Jeopardy that began on November 4, 2021 and was removed on November 11, 2021, when the facility inspected, audited, and reviewed all crash carts for necessary equipment; educated staff on equipment checklist for all crash carts; staff were educated on Code status, Physician order, Code event, and CPR procedures; and CPR procedures were reviewed prior to next shift. But noncompliance remained at a lower scope and severity of actual harm that is not immediate jeopardy because the facility needed to continue to ensure all nursing staff were educated on CPR procedures, reviewed a Code event, and all nursing staff were educated on crash cart complete audits. This Federal tag relates to Complaint IN00366741.			