STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1-075-1648	A. BUILDING B. WING	**02/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK AT HENRY MED CTR	**1050 HOSPITAL DRIVE STOCKBRIDGE, GA 30281**

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F 000	INITIAL COMMENTS	F 000		

An Abbreviated/Partial Extended Survey investigating complaints GA00192836, GA00192960, GA00193577, GA00193661 and GA00193672 was initiated on January 2, 2019 and concluded on January 3, 2019. Complaints GA00192836, GA00192960, GA00193577, and GA00193661 were unsubstantiated. After review by the State Survey Agency, further investigation was needed for complaint GA00193672, and a re-entry was initiated on January 28, 2019 and concluded on February 4, 2019. An additional complaint, GA00194099 was also investigated. Complaint GA00193672 was substantiated with deficiencies. Complaint GA00194099 was partially substantiated with deficiencies. As indicated on the facility's Form CMS-672, Resident Census and Conditions of Resident Form, the facility's census on January 3, 2019 was 83.

On January 29, 2019, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents.

The facility's Administrator, Nurse Consultant UUU, and Area Vice President were informed of the Immediate Jeopardy on January 29, 2019 at 4:15 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 19, 2018. The Immediate Jeopardy continued through January 29, 2019 and was removed on January 30, 2019.

The Immediate Jeopardy is outlined as follows:

1. Resident (R) #4 had not executed an Advance Directive. On December 19, 2018, R#4

was found in bed, unresponsive, with no vital signs. The resident's Advance Directive status was initially inaccurately assessed by licensed nursing staff as Do Not Resuscitate (DNR) in the electronic record, therefore, no emergency basic life support was immediately provided. The Physician and the Director of Health Services (DHS) were notified. While documenting the incident on a Situation, Background, Assessment, Recommendation (SBAR) form in the resident's clinical record the Licensed staff discovered that the resident had a full code status rather than a DNR status. Licensed nursing staff identified the error of the incorrect Advance Directive status approximately one hour after initially finding the resident unresponsive, at which time, the DHS initiated Cardiopulmonary Resuscitation (CPR) and Emergency Medical Services (EMS) were notified. EMS arrived and continued to provide additional emergency support. However, basic life support measures were not successful, and the DHS pronounced R#4's death on December 19, 2018 at 6:53 a.m.

2. R#12 experienced a change in condition on January 5, 2019. The resident was found in bed, unresponsive to all stimuli and without vital signs. The resident's Advance Directive status was listed in the electronic clinical record as DNR, therefore, licensed nursing staff did not provide emergency basic life support measures and R#12's death was pronounced at the facility on January 5, 2019 at 2:45 p.m. However, the DNR status in the clinical record was inaccurate. There was no supporting Physician's Order or signed DNR documentation to support the DNR status listed in the resident's clinical record.

Immediate Jeopardy was identified on January 29, 2019 and determined to exist on December 19, 2018 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F655; 42 CFR: 483.21 (v)(3)(i) Services Provided Meet Professional Standards, F658; 42 CFR: 483.24 (a)(3) Cardio-Pulmonary

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	Resuscitation (CPR), F678; 42 CFR 483.70 Administration, F835; 42 CFR: 483.20 (f)(5), 483.70 (i)(1)-(5) Resident Records-Identifiable Information, F842; 42 CFR 483.75 (d) Quality Assurance and Performance Improvement Activities, F867, all at a Scope and Severity (S/S) of a "J". Additionally, Substandard Quality of Care was identified at 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678. A Credible Allegation of Compliance was received on January 29, 2019. Based on interviews, record reviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 29, 2019. The facility remained out of compliance at a lower scope and severity of "D" while the facility continued management level staff oversight of the Advance Directive system and continued education. This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures.			

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F 0655 SS= J	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a	F 0655		

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	summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to develop a baseline care plan for the advance directive status for one resident (#4) from a total sample of 30 residents. An Abbreviated/Partial Extended Survey investigating complaints GA00192836, GA00192960, GA00193577, GA00193661 and GA00193672 was initiated on January 2, 2019 and concluded on January 3, 2019. Complaints GA00192836, GA00192960, GA00193577, and GA00193661 were unsubstantiated. After review by the State Survey Agency, further investigation was needed for complaint GA00193672, and a re-entry was initiated on January 28, 2019 and concluded on February 4, 2019. An additional complaint, GA00194099 was also investigated. Complaint GA00193672 was substantiated with deficiencies. Complaint GA00194099 was partially substantiated with deficiencies. As indicated on the facility's Form CMS-672, Resident Census and Conditions of Resident Form, the facility's census on January 3, 2019 was 83. On January 29, 2019, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood			

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to cause serious injury, harm, impairment or death to residents.

The facility's Administrator, Nurse Consultant UUU, and Area Vice President were informed of the Immediate Jeopardy on January 29, 2019 at 4:15 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 19, 2018. The Immediate Jeopardy continued through January 29, 2019 and was removed on January 30, 2019.

The Immediate Jeopardy is outlined as follows:

1. Resident (R) #4 had not executed an Advance Directive. On December 19, 2018, R#4 was found in bed, unresponsive, with no vital signs. The resident's Advance Directive status was initially inaccurately assessed by licensed nursing staff as Do Not Resuscitate (DNR) in the electronic record, therefore, no emergency basic life support was immediately provided. The Physician and the Director of Health Services (DHS) were notified. While documenting the incident on a Situation, Background, Assessment, Recommendation (SBAR) form in the resident's clinical record the Licensed staff discovered that the resident had a full code status rather than a DNR status. Licensed nursing staff identified the error of the incorrect Advance Directive status approximately one hour after initially finding the resident unresponsive, at which time, the DHS initiated Cardiopulmonary Resuscitation (CPR) and Emergency Medical Services (EMS) were notified. EMS arrived and continued to provide additional emergency support. However, basic life support measures were not successful, and the DHS pronounced R#4's death on December 19, 2018 at 6:53 a.m.

2. R#12 experienced a change in condition on January 5, 2019. The resident was found in bed, unresponsive to all stimuli and without vital

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	signs. The resident's Advance Directive status was listed in the electronic clinical record as DNR, therefore, licensed nursing staff did not provide emergency basic life support measures and R#12's death was pronounced at the facility on January 5, 2019 at 2:45 p.m. However, the DNR status in the clinical record was inaccurate. There was no supporting Physician's Order or signed DNR documentation to support the DNR status listed in the resident's clinical record. Immediate Jeopardy was identified on January 29, 2019 and determined to exist on December 19, 2018 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F655; 42 CFR: 483.21 (v)(3)(i) Services Provided Meet Professional Standards, F658; 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678; 42 CFR 483.70 Administration, F835; 42 CFR: 483.20 (f)(5), 483.70 (i)(1)-(5) Resident Records-Identifiable Information, F842; 42 CFR 483.75(d) Quality Assurance and Performance Improvement Activities, F867, all at a Scope and Severity (S/S) of a "J". Additionally, Substandard Quality of Care was identified at 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678. A Credible Allegation of Compliance was received on January 29, 2019. Based on interviews, record reviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 29, 2019. The facility remained out of compliance at a lower scope and severity of "D" while the facility continued management level staff oversight of the Advance Directive system and continued education. This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures.			

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Findings include:

R#4 was admitted to the facility on 12/3/18. A review of the "Georgia Advance Directive for Healthcare" and "DNR" forms, signed by the resident's responsible party on 12/4/18 revealed that the resident had not executed an Advance Directive and did not have a DNR order.

A base line care plan was developed that included problems with dates of 12/3/18 and 12/12/18 and 12/14/18. However, the care plan did not include the resident's Advance Directive status.

During an interview on 1/28/19 at 4:30 p.m., the DHS stated that the Advance Directive/Code Status is verified in the electronic clinical record at the top of the computer screen, on the banner. If there is no Advance Directive/Code Status listed there, you assume the resident is a full code (not a DNR). She stated that there is no need to scroll down to the Advance Directive section of the chart because whatever is checked in that section will appear on the banner (at the top of the screen). The DHS confirmed that the Advanced Directive status was not included on the Baseline Care Plan for R#4 which should have been completed by the admitting nurse and was not completed.

Cross refer to F678

The facility implemented the following actions to remove the Immediate Jeopardy:

Each Resident must have a Resident centered baseline care plan, followed by a comprehensive care plan developed following completion of the Minimum Data Set and Care

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	Area assessment portion of the comprehensive assessment according to the Resident Assessment Instrument manual and the Resident's choice. Root Cause Analysis The facility failed to develop a Baseline Care Plan to reflect current code status for Resident #4. This Immediate Jeopardy was abated on 01/30/19, at which time the facility completed the following actions: 1) MDS Nurses, Senior Nurse Consultant Completed an audit of all resident care plans to ensure correct code status on care plan on 01/29/2019. MDS Nurse completed an audit of resident care plans on 01/29/19 for residents with DNR and Full Code Advance Directives. 2) Resident #4 and Resident #12's Care Plan was updated to reflect their Advanced Directives. Director of Health Services and Administrator completed an audit of all active resident records on 01/29/2019 to ensure the residents care plans were accurate. There were no other Residents identified during the audit with inaccurate Care Plans. 3) Care Plan Coordinator/MDS Nurse educated by Senior Nurse Consultant on 01/29/19 to initiate Advanced Directives/Do Not Resuscitate/Full Code Care Plan once an order is received. As of 01/30/19 we have trained 2/2 activity (100%), 2/2 Maintenance (100%), Administration 7/7 (100%), Housekeeping & Laundry 11/11 (100%), Dietary 7/10 (70%), Certified Nursing Assistant 25/31 (81%), Licensed Practical Nurses 14/16 (88%), Registered Nurses 11/11 (100%), Therapist 15/20 (75%). Staff that have not been trained as of 01/30/2019 will be trained prior to working			

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their next shift. All new hires will be trained during orientation on baseline care plans for an Advanced Directive. The Director of Health Services and/or Unit Manager will monitor this process in clinical stand-up by reviewing all new orders and ensuring any Do Not Resuscitate or Full Code orders are carried through to the care plan. This process will be documented on the Advance Directives Checklist by the Director of Health Services or Unit Manager.

4) The facilities policy has been reviewed and is current. The policy was reviewed on 01/29/2019.

5) Findings will be reported in Quality Assurance Performance Improvement Committee by the Director of Health Services or Unit manager x3 months.

The State Survey Agency (SSA) validated the facility's Credible Allegation of Immediate Jeopardy Removal as follows:

1. An interview and record review with the Minimum Data Set (MDS) Coordinator on 2/4/19 at 12:45 p.m. revealed that chart audits have been completed daily for Advance Directives and corresponding care plans from 12/19/18 through 1/28/19. She further stated that as of 1/29/19 the audits include that the correct Code Status and that the corresponding paper work is included in the resident's record.

2. Review and verification of the facility's audit documents, care plans and Advance Directive documentation for residents with a DNR is specified in the resident's chart.

3. The following interviews were conducted on 2/4/19 with Licensed Practical Nurses (LPN)

confirming they have attended in-services on 1/29/19 related to developing a Base Line Care Plan for Code Status: LPN HH at 12:27 p.m., LPN PP, Unit Manager, at 12:39 p.m., LPN RR at 12:47 p.m. and LPN WW at 1:00 p.m.

The following Registered Nurses (RN) were interviewed on 2/4/19 confirming attending in-services regarding the development of Base Line Care Plans for Code Status on 1/29/19: RN KK at 12:29 p.m., RN DD at 12:34 p.m., RN SS at 12:51 p.m., RN VV (Assistant Director of Health Services-ADHS) at 12:53 p.m., RN ZZ at 1:04 p.m., RN HHH (DHS) at 1:21 p.m., RN III at 1:25 p.m. and RN CC at 12:33 p.m.

The following Certified Nursing Assistants (CNA) were interviewed on 2/4/19, confirming they had attended in-services on 1/29/19 related to developing a Base Line Care Plan for Code Status and their role in the process: CNA II at 12:27 p.m., CNA JJ at 12:29 p.m., CNA MM and CNA NN at 12:36 p.m., CNA OO at 12:39 p.m., CNA QQ at 12:47 p.m., CNA TT and CNA SS at 12:51 p.m., CNA UU at 12:53 p.m., CNA YY at 1:04 p.m., CNA AAA and CNA BBB at 1:09 p.m., CNA CCC at 1:12 p.m. and CNA GGG at 12:21 p.m.

The following interviews were conducted on 2/4/19 related to in-services on 1/29/19 confirming they had attended in-services on Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: Admission Coordinator LL at 12:34 p.m., Activity Director XX at 1:00 p.m., Social Worker DDD at 1:12 p.m., Front office staff EEE and FFF at 1:18 p.m., Maintenance staff JJJ and KKK at 1:34 p.m., Dietary Aides LLL and MMM at 1:40 p.m., Cooks NNN and OOO at 1:43 p.m., Housekeeping Staff PPP and QQQ at 1:48 p.m. and Housekeeping staff RRR and SSS at 1:50 p.m. and Laundry staff TTT at 1:54 p.m.

4. Per interview and review of the Care Plan

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	Policy, confirmed that the facility Baseline Care Plan Policy was reviewed and approved on 1/29/19 with input from the Medical Director and Nursing. The policy was signed by the Administrator on 1/29/19. 5. Record review and interviews with the Administrator and DHS on 2/4/19 at 1:15 p.m. and 2:32 p.m. which confirmed that a QA meeting was held on 12/19/18 after the death of R#4 to put a plan into place which included an audit of all resident's records for Advanced Directive Status. Additionally, a QA meeting was held on 1/29/19, which included the Medical Director (via telephone) to update the plan to address the Advance Directive error and review the affected policies of the facility, which included Base Line and Comprehensive Care Plans.			
F 0658 SS= J	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, policy review and review of the "Georgia Nurse Practice Act" the facility failed to ensure that accepted standards of clinical practice were followed regarding accurately assessing a resident's advance directive status for one resident (#4) from a total sample of 30 residents. An Abbreviated/Partial Extended Survey investigating complaints GA00192836, GA00192960, GA00193577, GA00193661 and GA00193672 was initiated on January 2, 2019	F 0658		

and concluded on January 3, 2019. Complaints GA00192836, GA00192960, GA00193577, and GA00193661 were unsubstantiated. After review by the State Survey Agency, further investigation was needed for complaint GA00193672, and a re-entry was initiated on January 28, 2019 and concluded on February 4, 2019. An additional complaint, GA00194099 was also investigated. Complaint GA00193672 was substantiated with deficiencies. Complaint GA00194099 was partially substantiated with deficiencies. As indicated on the facility's Form CMS-672, Resident Census and Conditions of Resident Form, the facility's census on January 3, 2019 was 83.

On January 29, 2019, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents.

The facility's Administrator, Nurse Consultant UUU, and Area Vice President were informed of the Immediate Jeopardy on January 29, 2019 at 4:15 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 19, 2018. The Immediate Jeopardy continued through January 29, 2019 and was removed on January 30, 2019.

The Immediate Jeopardy is outlined as follows:

1. Resident (R) #4 had not executed an Advance Directive. On December 19, 2018, R#4 was found in bed, unresponsive, with no vital signs. The resident's Advance Directive status was initially inaccurately assessed by licensed nursing staff as Do Not Resuscitate (DNR) in the electronic record, therefore, no emergency basic life support was immediately provided. The Physician and the Director of Health Services (DHS) were notified. While

documenting the incident on a Situation, Background, Assessment, Recommendation (SBAR) form in the resident's clinical record the Licensed staff discovered that the resident had a full code status rather than a DNR status. Licensed nursing staff identified the error of the incorrect Advance Directive status approximately one hour after initially finding the resident unresponsive, at which time, the DHS initiated Cardiopulmonary Resuscitation (CPR) and Emergency Medical Services (EMS) were notified. EMS arrived and continued to provide additional emergency support. However, basic life support measures were not successful, and the DHS pronounced R#4's death on December 19, 2018 at 6:53 a.m.

2. R#12 experienced a change in condition on January 5, 2019. The resident was found in bed, unresponsive to all stimuli and without vital signs. The resident's Advance Directive status was listed in the electronic clinical record as DNR, therefore, licensed nursing staff did not provide emergency basic life support measures and R#12's death was pronounced at the facility on January 5, 2019 at 2:45 p.m. However, the DNR status in the clinical record was inaccurate. There was no supporting Physician's Order or signed DNR documentation to support the DNR status listed in the resident's clinical record.

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	Additionally, Substandard Quality of Care was identified at 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678. A Credible Allegation of Compliance was received on January 29, 2019. Based on interviews, record reviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 29, 2019. The facility remained out of compliance at a lower scope and severity of "D" while the facility continued management level staff oversight of the Advance Directive system and continued education. This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures. Findings include: The facility did have an "Advance Directives: Georgia" policy. Review of the policy statement included that the healthcare center recognizes the right of residents to control decisions related to their medical care. The policy procedure included that prior to, or upon admission, the resident and/or their responsible party will be asked about the existence of any Advance Directives and that the Advance Directive Checklist will be completed. The facility had a "Do Not Resuscitate Policy: Georgia" policy. The policy statement included that unless an order to withhold life-sustaining treatment is entered on the resident's medical record, life-sustaining treatment will be performed on all residents if it is medically justified. Review of the Rules and Regulations of the State of Georgia, Rule 410-10-.02 Standards of Practice for Licensed Practical Nurse addressed			

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	1-075-1648	A. BUILDING B. WING	02/04/2019

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	Rule 410-10-.02 (a) Participating in patient assessment activities and the planning, implementation, and evaluation of the delivery of health care services and other specialized tasks when appropriately educated and consistent with board rules and regulations; (b) Providing direct personal patient observation, care, and assistance in hospitals, clinics, nursing homes, or emergency treatment facilities, or health care facilities in area of practice including, but not limited to: coronary care, intensive care, emergency treatment, surgical care and recovery, obstetrics, pediatrics, outpatient services, dialysis, specialty labs, home health care, or other such areas of practice. (f) Performing other specialized tasks as appropriately educated. 2. Responsibility: Each individual is responsible for personal acts of negligence under the law. Licensed practical nurses are liable if the perform functions for which they are not prepared by education and experience and for which supervision is not provided. 1. R#4 was admitted to the facility on 12/3/18 with diagnoses that included acute on chronic systolic heart failure, atherosclerotic heart disease, difficulty walking, muscle weakness, dysphagia, ischemic cardiomyopathy, hypertension, hyperlipidemia, type 2 diabetes, and chronic kidney disease. In addition, progress notes documented the resident was status post a fall and left eye surgery, prior to admission. A "GA Advance Directive for Healthcare" form and "DNR" form, were signed by the resident's responsible party on 12/4/18. The "Georgia Advance Directive for Healthcare" form documented that the resident had not executed an Advance Directive and did not wish to discuss Advance Directives further at that time. The "DNR" form documented that the resident did not have a DNR order or Physician Orders for Life-Sustaining Treatment (POLST) in place and did not wish to discuss DNR orders further at that time.			

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R#4 experienced a change in condition on 12/19/18. A nurse's note dated 12/19/18 at 5:22 a.m., documented that upon entering the resident's room, the resident was unresponsive to verbal and physical stimuli. The note also documented that nursing staff were unable to obtain a blood pressure, pulse, respirations or pulse oximetry, and the resident's temperature was 90.3 degrees. The DHS was notified, and a message was left for the on-call physician. There was no evidence that emergency basic life support measures were immediately implemented.

The subsequent nurse's note, approximately one hour later, on 12/19/18 at 6:25 p.m. documented that CPR was started. Further review of nurses' notes entries revealed that EMS personnel were onsite and took over CPR at 6:30 a.m. and continued emergency life support measures, but without success. EMS personnel received a Physician's Order to cease efforts and the resident's death was pronounced at the facility on 12/19/18 at 6:53 a.m.

During an interview on 1/29/19 at 7:35 a.m., Licensed Practical Nurse (LPN) AA stated that, after finding the resident unresponsive and unable to obtain vital signs, she checked the resident's electronic chart. She stated that she thought she saw DNR on the Advance Directives section of the chart and notified the DHS. However, when she started the paperwork, she could not find DNR information and called the DHS again, who arrived shortly afterward and called 911 and began CPR. LPN AA stated that she would have started CPR immediately, if she had not thought she saw DNR on the electronic chart.

During an interview on 1/28/19 at 4:30 p.m., the DHS confirmed that she received a call from LPN AA the morning of 12/19/18 regarding

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	resident #4's passing and that the resident was a DNR. The DHS stated while enroute to the facility to pronounce the resident's death, she received another phone call from LPN AA notifying her that she could not locate the DNR information. The DHS stated she arrived shortly afterward, reviewed the chart, and in seeing no Advance Directive status specified, called 911 and initiated CPR. The DHS stated that Advance Directive/Code Status is verified in the electronic clinical record at the top of the computer screen, on the banner. If there is no Advance Directive/Code Status listed there, you assume the resident is a full code (not a DNR). She stated that there is no need to scroll down to the Advance Directive section of the chart because whatever is checked in that section will appear on the banner (at the top of the screen). 2. Review of the Medical record revealed that R#12 was admitted to the facility on 1/4/19 and had diagnoses that included displaced bicondylar fracture of left tibia, history of falling, influenza A, atrial fibrillation, osteoarthritis of the left knee, Alzheimer's disease and dementia without behavioral disturbance. Review of the "Physician Order Report" covering period 1/4/19 through 1/29/19 indicated R#12 was to be a Do Not Resuscitate (DNR). However, review of the electronic medical record revealed there were no supporting documents to validate the resident's DNR status. Review of the "Resident Progress Notes" dated 1/5/19 at 3:00 p.m. revealed that at 2:40 p.m. the nurse was notified by a family member that the resident was unresponsive to all stimuli. The note further documented that the resident was assessed by two nurses and found to be without any vital signs. At 2:45 p.m. the funeral home was notified and was awaiting arrival of the funeral home personnel. The resident had an announcement of death by the Registered			

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Nurse on 1/5/19 at 2:45 p.m.

During an interview with Licensed Practical Nurse (LPN) BB on 1/29/19 at 11:35 a.m., she stated that the resident's daughter had reported to her the resident was not responding. She stated that she went and got Registered Nurse (RN) CC who got the crash cart and when they entered the room the resident's son told them the resident was a DNR. She stated when she checked the face sheet she saw where the resident was a DNR and they did not do Cardiopulmonary Resuscitation (CPR).

During an interview with RN CC on 1/29/19 at 12:03 p.m., she stated that LPN BB came to her and said the resident was nonresponsive. She grabbed the crash cart while LPN BB got the electronic record to check the resident's code status. As they were entering the room, LPN BB stated the resident was a DNR. She also stated that as they were entering the resident's room, the son asked them what they were doing with the crash cart since his mother was a DNR. She stated she went in the room to assess the resident who did not have a pulse, no respirations and her pupils were fixed and dilated. She stated that she was the nurse who pronounced the resident's death.

During an interview with Nurse Consultant UUU on 1/29/19 at 10:30 a.m., she provided a copy of the resident's Advanced Health Care Directive which was faxed from the hospital. However, the fax date was 1/29/19 at 9:22 a.m. She stated that the facility did not have a copy of the Advanced Directive until after surveyor inquiry on 1/29/19, 25 days after the resident's admission date. She also stated that the family told the facility they would bring a copy of the Advanced Directive on the following Monday, the seventh. She stated the resident should have been a full code until they had a copy of the Advanced Directive.

The facility had an "Advance Directive: Georgia" policy and "Do Not Resuscitate Policy: Georgia" policy in place to address obtaining and maintaining resident Advance Directive documentation in the clinical record. In addition, the facility began using an electronic charting system 11/1/18. However, there was no evidence that the Advance Directive system was routinely monitored by the Administrator, to ensure that it was accurately and consistently implemented.

During an interview on 1/31/19 at 1:50 p.m., the Administrator confirmed that she was not aware of any concerns regarding advance directive completion and accuracy in the clinical record prior to R#4's and R#12's deaths. The Administrator revealed that the new electronic medical system was begun on 11/1/18 and that staff were in-serviced on how to use the new system on 11/13/18 and 11/14/18 as the specific systems went online. The Administrator supplied the training agenda and sign in sheets for the 11/14/18 in-service which covered Resident Charting, Resident Banner items, Entering documentation for the DHS, Nurse Leaders and Nurses. LPN AA was present and signed in for the in-service.

Cross refer to F678

The facility implemented the following actions to remove the Immediate Jeopardy:

We will ensure that professional care and services are provided according to accepted standards of clinical practice to achieve desired Resident outcomes.

Root Cause Analysis

The Licensed Practical Nurse failed to provide

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life sustaining measures for Resident #4. The Licensed Practical Nurse incorrectly identified that the resident was a Do Not Resuscitate. The system that failed was the Full Code status was not entered into the electronic medical record. The Licensed Practical Nurse failed to verify the code status in the resident documents.

This Immediate Jeopardy was abated on 1/30/19, at which time the facility completed the following actions:

1) Senior Nurse Consultant continued education and re-education for all staff on Advance Directives, CPR protocol and explanation of deficient practice.

2) All staff will be educated from 01/29/19 to completion by the Director of Health Services and Clinical Competency Coordinator to verify code status via Resident chart. As of 01/30/19, 2/2 activity (100%), 2/2 Maintenance (100%), Administration 7/7 (100%), Housekeeping & Laundry 11/11 (100%), Dietary 7/10 (70%), Certified Nursing Assistant 25/31 (81%), Licensed Practical Nurses 14/16 (88%), Registered Nurses 11/11 (100%), Therapist 15/20 (75%). Staff that have not been trained as of 01/30/2019 will be trained prior to working their next shift. All new hires will be trained during orientation on baseline care plans. Director of Health Services and Administrator completed an audit of all active resident records on 01/29/2019 to ensure the residents Advanced Directive was accurate and in the electronic medical record.

3) The facility follows "professional standards of quality." There is no facility policy. The "professional standards of quality" was reviewed on 01/29/2019.

4) The Director of Health Services and or Unit Manager will monitor this process in clinical stand-up by reviewing all new orders and

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	ensuring any Do Not Resuscitate or Full Code orders are in the electronic medical record and the banner is correct. This process will be documented on the Advance Directives Checklist by the Director of Health Services or Unit Manager. 5) Findings will be reported in Quality Assurance Performance Improvement by the Director of Health Services or Unit manager x3 months. The State Survey Agency (SSA) validated the facility's Credible Allegation of Immediate Jeopardy Removal as follows: 1. Review of in-service records for 1/29/19 regarding Advanced Directive: Policy, how to enter Advanced Directives into the electronic record on admission or change in condition, what to do if Code Status changes, reading the full-face sheet in the electronic record, Complete assessments on admission to include Advance Directives and who is responsible for maintaining accurate information. 1/29/19 DNR policy, Verification of Code Status, Accurate Code Status in the electronic record, Physician Order verification upon admission in the electronic record, confirming that electronic record has accurate Code Status on the resident's banner. Staff were also educated on the 1/29/19 Immediate Jeopardy results and definitions. All in-services were completed by the Nurse Consultant UUU. 2. Review of in-service sign in sheets to confirm staff attended the in-services. The following interviews were conducted on 2/4/19 with Licensed Practical Nurses (LPN) confirming they have attended in-services on 1/29/19 related to Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the			

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	electronic record and to confirm the accuracy of the resident's code status: LPN HH at 12:27 p.m., LPN PP, Unit Manager, at 12:39 p.m., LPN RR at 12:47 p.m. and LPN WW at 1:00 p.m. The following Registered Nurses (RN) were interviewed on 2/4/19 confirming attending in-services regarding the Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status on 1/29/19: RN KK at 12:29 p.m., RN DD at 12:34 p.m., RN SS at 12:51 p.m., RN VV (Assistant Director Health Services-ADHS) at 12:53 p.m., RN ZZ at 1:04 p.m., RN HHH (DHS) at 1:21 p.m., RN III at 1:25 p.m. and RN CC at 12:33 p.m. The following Certified Nursing Assistants (CNA) were interviewed on 2/4/19, confirming they had attended in-services on 1/29/19 related to Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: CNA II at 12:27 p.m., CNA JJ at 12:29 p.m., CNA MM and CNA NN at 12:36 p.m., CNA OO at 12:39 p.m., CNA QQ at 12:47 p.m., CNA TT and CNA SS at 12:51 p.m., CNA UU at 12:53 p.m., CNA YY at 1:04 p.m., CNA AAA and CNA BBB at 1:09 p.m., CNA CCC at 1:12 p.m. and CNA GGG at 12:21 p.m. The following interviews were conducted on 2/4/19 related to in-services on 1/29/19 confirming they had attended in-services on Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: Admission Coordinator LL at 12:34 p.m., Activity Director XX at 1:00 p.m., Social Worker DDD at 1:12 p.m., Front office staff EEE and			

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	FFF at 1:18 p.m., Maintenance staff JJJ and KKK at 1:34 p.m., Dietary Aides LLL and MMM at 1:40 p.m., Cooks NNN and OOO at 1:43 p.m., Housekeeping Staff PPP and QQQ at 1:48 p.m. and Housekeeping staff RRR and SSS at 1:50 p.m. and Laundry staff TTT at 1:54 p.m. 3. Review of "professional standards of quality" to confirm review on 1/29/19 which was signed by the Administrator on 1/29/19. 4. Review and interview with the DHS on 2/4/19 at 1:15 p.m. of completed Advance Directives checklist. 5. Confirmed via interview with the DHS on 2/4/19 at 1:15 p.m. that the completed Advance Directive checklist will be reviewed by the QAPI committee monthly.			
F 0678 SS= J	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 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 interviews and record review, the facility failed to accurately assess the Advance Directive status for one resident (#4) and failed to accurately document the Advance Directive status for one resident (#12) from a total sample of 30 residents. An Abbreviated/Partial Extended Survey investigating complaints GA00192836, GA00192960, GA00193577, GA00193661 and GA00193672 was initiated on January 2, 2019	F 0678		

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	and concluded on January 3, 2019. Complaints GA00192836, GA00192960, GA00193577, and GA00193661 were unsubstantiated. After review by the State Survey Agency, further investigation was needed for complaint GA00193672, and a re-entry was initiated on January 28, 2019 and concluded on February 4, 2019. An additional complaint, GA00194099 was also investigated. Complaint GA00193672 was substantiated with deficiencies. Complaint GA00194099 was partially substantiated with deficiencies. As indicated on the facility's Form CMS-672, Resident Census and Conditions of Resident Form, the facility's census on January 3, 2019 was 83. On January 29, 2019, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Nurse Consultant UUU, and Area Vice President were informed of the Immediate Jeopardy on January 29, 2019 at 4:15 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 19, 2018. The Immediate Jeopardy continued through January 29, 2019 and was removed on January 30, 2019. The Immediate Jeopardy is outlined as follows: 1. Resident (R) #4 had not executed an Advance Directive. On December 19, 2018, R#4 was found in bed, unresponsive, with no vital signs. The resident's Advance Directive status was initially inaccurately assessed by licensed nursing staff as Do Not Resuscitate (DNR) in the electronic record, therefore, no emergency basic life support was immediately provided. The Physician and the Director of Health Services (DHS) were notified. While			

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	documenting the incident on a Situation, Background, Assessment, Recommendation (SBAR) form in the resident's clinical record the Licensed staff discovered that the resident had a full code status rather than a DNR status. Licensed nursing staff identified the error of the incorrect Advance Directive status approximately one hour after initially finding the resident unresponsive, at which time, the DHS initiated Cardiopulmonary Resuscitation (CPR) and Emergency Medical Services (EMS) were notified. EMS arrived and continued to provide additional emergency support. However, basic life support measures were not successful, and the DHS pronounced R#4's death on December 19, 2018 at 6:53 a.m. 2. R#12 experienced a change in condition on January 5, 2019. The resident was found in bed, unresponsive to all stimuli and without vital signs. The resident's Advance Directive status was listed in the electronic clinical record as DNR, therefore, licensed nursing staff did not provide emergency basic life support measures and R#12's death was pronounced at the facility on January 5, 2019 at 2:45 p.m. However, the DNR status in the clinical record was inaccurate. There was no supporting Physician's Order or signed DNR documentation to support the DNR status listed in the resident's clinical record. Immediate Jeopardy was identified on January 29, 2019 and determined to exist on December 19, 2018 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F655; 42 CFR: 483.21 (v)(3)(i) Services Provided Meet Professional Standards, F658; 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678; 42 CFR 483.70 Administration, F835; 42 CFR: 483.20 (f)(5), 483.70 (i)(1)-(5) Resident Records-Identifiable Information, F842; 42 CFR 483.75(d) Quality Assurance and Performance Improvement Activities, F867, all at a Scope and Severity (S/S) of a "J".			

Additionally, Substandard Quality of Care was identified at 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678.

A Credible Allegation of Compliance was received on January 29, 2019. Based on interviews, record reviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 29, 2019. The facility remained out of compliance at a lower scope and severity of "D" while the facility continued management level staff oversight of the Advance Directive system and continued education. This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures.

Findings include:

The facility had an "Advance Directives: Georgia" policy. The policy statement included that the healthcare center recognizes the right of residents to control decisions related to their medical care. The policy procedure included that prior to, or upon admission, the resident and/or their responsible party will be asked about the existence of any advance directives. The Advance Directive Checklist will be completed.

During an interview on 1/29/19 at 11:10 a.m., Nurse Consultant UUU stated that the facility went live with using an electronic clinical record system on 11/1/18 and that the staff was trained on the system as the different components came on line. The facility provided an agenda for the staff training for 11/14/18 through 11/16/18 and sign in sheets for the training.

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	1. R#4 was admitted to the facility on 12/3/18 with diagnoses that included acute on chronic systolic heart failure, atherosclerotic heart disease, difficulty walking, muscle weakness, dysphagia, ischemic cardiomyopathy, hypertension, hyperlipidemia, type 2 diabetes, and chronic kidney disease. In addition, progress notes documented the resident was status post a fall and left eye surgery, prior to admission. A "Georgia Advance Directive for Healthcare" form and "DNR" form, were signed by the resident's responsible party on 12/4/18. The "Georgia Advance Directive for Healthcare" form documented that the resident had not executed an Advance Directive and did not wish to discuss Advance Directives further at that time. The "DNR" form documented that the resident did not have a DNR order or Physician Orders for Life-Sustaining Treatment (POLST) in place and did not wish to discuss DNR orders further at that time. R#4 experienced a change in condition on 12/19/18. A nurse's note dated 12/19/18 at 5:22 a.m., documented that upon entering the resident's room, the resident was unresponsive to verbal and physical stimuli. The note also documented that they were unable to obtain a blood pressure, pulse, respirations or pulse oximetry, and her temperature was 90.3 degrees. The DHS was notified, and a message was left for the on-call physician. There was no evidence that emergency basic life support measures were immediately implemented. The subsequent nurse's note, approximately one hour later, on 12/19/18 at 6:25 p.m. documented that CPR was started. Further review of nurses' notes entries revealed that EMS personnel were onsite and took over CPR at 6:30 a.m. and continued emergency life support measures, but without success. EMS personnel received a Physician's Order to cease efforts and the resident's death was pronounced at the facility on 12/19/18 at 6:53 a.m.			

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	1-075-1648	A. BUILDING B. WING	02/04/2019

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During an interview on 1/29/19 at 7:35 a.m., Licensed Practical Nurse (LPN) AA stated that, after finding the resident unresponsive and unable to obtain vital signs, she checked the resident's electronic chart. She stated that she thought she saw DNR on the Advance Directives section of the chart and notified the DHS. However, when she started the paperwork, she could not find DNR information and called the DHS again, who arrived shortly afterward and called 911 and began CPR. LPN AA stated that she would have started CPR immediately, if she had not thought she saw DNR on the electronic chart.

During an interview on 1/28/19 at 4:30 p.m., the DHS confirmed that she received a call from LPN AA the morning of 12/19/18 regarding resident #4's passing and that the resident was a DNR. The DHS stated while enroute to the facility to pronounce the resident's death, she received another phone call from LPN AA notifying her of that she could not locate DNR information. The DHS stated she arrived shortly afterward, reviewed the chart, and in seeing no Advance Directive status specified, called 911 and initiated CPR. The DHS stated that Advance Directive/Code Status is verified in the electronic clinical record at the top of the computer screen, on the banner. If there is no Advance Directive/Code Status listed there, you assume the resident is a full code (not a DNR). She stated that there is no need to scroll down to the Advance Directive section of the chart because whatever is checked in that section will appear on the banner (at the top of the screen).

During an interview on 1/31/19 at 1:50 p.m., the Administrator stated that she was notified of R#4's death on 12/19/18. In response to the incident, she interviewed staff, called a Quality Assurance Plan Improvement (QAPI) meeting (on 12/19/18), put a plan in place and began auditing residents' Advance Directive status in

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	the clinical records. A review of the plan revealed that it included the following specifics: The facility identified that all residents had the potential to be affected. A. The DHS and Assistant Director of Health Services (ADHS) would educate all nurses on the Advance Directives policy and procedures. All nurses would also be educated on the facility's electronic clinical record system integration related to Advance Directives. All training was initiated on 12/19/18 and would be completed by 12/21/18 with all nurses being educated prior to the start of their next shift. B. The Administrator or designee would complete a daily audit tool to monitor Advance Directives for four weeks. The DHS and ADHS would complete a weekly audit tool to monitor compliance for four weeks. A QAPI committee meeting would be held on 1/17/19 to ensure the audit was correct and that no other issues were identified. However, despite the facility's implemented interventions to ensure the Advance Directives were integrated into the electronic clinical record, they failed to ensure that the Advance Directives status was accurate with supporting Advance Directive documentation. 2. Review of the Medical record revealed that R#12 was admitted to the facility on 1/4/19 and had diagnoses that included displaced bicondylar fracture of left tibia, history of falling, influenza A, atrial fibrillation, osteoarthritis of the left knee, Alzheimer's disease and dementia without behavioral disturbance. Review of the "Physician Order Report" covering period 1/4/19 through 1/29/19 indicated R#12 was to be a Do Not Resuscitate (DNR). However, review of the electronic medical record revealed there were no			

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supporting documents to validate the resident's DNR status.

Review of the "Resident Progress Notes" dated 1/5/19 at 3:00 p.m. revealed that at 2:40 p.m. the nurse was notified by a family member that the resident was unresponsive to all stimuli. The note further documented that the resident was assessed by two nurses and found to be without any vital signs. At 2:45 p.m. the funeral home was notified and was awaiting arrival of the funeral home personnel. The resident had an pronouncement of death by RN CC on 1/5/19 at 2:45 p.m.

During an interview with Licensed Practical Nurse (LPN) BB on 1/29/19 at 11:35 a.m., she stated that the resident's daughter had reported to her the resident was not responding. She stated that she went and got Registered Nurse (RN) CC who got the crash cart and when they entered the room the resident's son told them the resident was a DNR. She stated when she checked the face sheet she saw where the resident was a DNR and they did not do Cardiopulmonary Resuscitation (CPR).

During an interview with RN CC on 1/29/19 at 12:03 p.m., she stated that LPN BB came to her and said the resident was nonresponsive. She grabbed the crash cart while LPN BB got the electronic record to check the resident's code status. As they were entering the room, LPN BB stated the resident was a DNR. She also stated that as they were entering the resident's room, the son asked them what they were doing with the crash cart since his mother was a DNR. She stated she went in the room to assess the resident who did not have a pulse, no respirations, and her pupils were fixed and dilated. She stated that she was the nurse who pronounced the resident's death.

During an interview with Nurse Consultant UUU

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on 1/29/19 at 10:30 a.m., she provided a copy of the resident's Advanced Health Care Directive which was faxed from the hospital. However, the fax date was 1/29/19 at 9:22 a.m. She stated that the facility did not have a copy of the Advanced Directive until after surveyor inquiry on 1/29/19, 25 days after the resident's admission date. She also stated that the family told the facility they would bring a copy of the Advanced Directive on the following Monday, the seventh. She stated the resident should have been a full code until they had a copy of the Advanced Directive.

The facility implemented the following actions to remove the Immediate Jeopardy:

Personnel will provide basic life support including CPR to a Resident requiring such emergency care before the arrival of emergency medical personnel and subject to related physicians order and Residents Advanced Directive.

Root Cause Analysis

Nursing staff did not provide CPR on Resident #4 and Resident #12.

This Immediate Jeopardy was abated on 01/30/19, at which time the facility completed the following actions:

1) Clinical Competency Coordinator or designee will ensure all staff know how to confirm the Residents Advanced Directives.

2) All staff were educated on 01/29/19. As of 01/30/19 we trained 2/2 activity (100%), 2/2 Maintenance (100%), Administration 7/7

(100%), Housekeeping & Laundry 11/11 (100%), Dietary 7/10 (70%), Certified Nursing Assistant 25/31 (81%), Licensed Practical Nurses 14/16 (88%), Registered Nurses 11/11 (100%), Therapist 15/20 (75%) by the Director of Health Services and the Clinical Competency Coordinator to verify code status via Resident chart. Staff that have not been trained as of 01/30/2019 will be trained prior to working their next shift. All new hires will be trained on during orientation on basic life support including CPR. Director of Health Services and Administrator completed an audit with all staff on 01/29/2019 to ensure the staff know how to confirm the Residents medical record.

3) The facilities policy has been reviewed and is current. The policy was reviewed on 01/29/2019.

4) Clinical Competency Coordinator or Director of Health Services will randomly audit 10% of all staff weekly to ensure staff knows how to confirm residents code status by return demonstration. Administrator or designee will audit Advanced Directives in the electronic medical record daily x2 months or until substantial compliance is complete.

5) Findings will be communicated by the Director of Health Services at Quality Assurance Performance Improvement monthly x3 months.

The State Survey Agency (SSA) validated the facility's Credible Allegation of Immediate Jeopardy Removal as follows:

1. An interview with Registered Nurse CC (Clinical Care Coordinator) on 2/4/19 at 12:33 p.m. revealed that staff were in-serviced on 1/29/19 and any remaining staff were in-serviced before starting their next shift at the facility.

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2. The following interviews revealed that all of the staff were able to describe the in-service training for the Advance Directives, Code Status and care planning for Code Status. They stated they have had three to four classes on the topics and then a refresher was done every day where the management would come ask them questions and some had to do a return demonstration to make sure they understood. They were able to describe where to find the resident's Code Status, the banner and in resident electronic documents. They also stated if there was no Code Status on the banner or the documents that the resident would be full code and they would have to start CPR. They stated the resident would be a full code until the proper documents were provided. They also discussed the care plans, where the Code Status would also be included.

The following interviews were conducted on 2/4/19 with Licensed Practical Nurses (LPN) confirming they have attended in-services on 1/29/19 related to Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: LPN HH at 12:27 p.m., LPN PP, Unit Manager, at 12:39 p.m., LPN RR at 12:47 p.m. and LPN WW at 1:00 p.m.

The following Registered Nurses (RN) were interviewed on 2/4/19 confirming attending in-services regarding the Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status on 1/29/19: RN KK at 12:29 p.m., RN DD at 12:34 p.m., RN SS at 12:51 p.m., RN VV (Assistant Director Health Services-ADHS) at 12:53 p.m., RN ZZ at 1:04 p.m., RN HHH (DHS) at 1:21 p.m., RN III at 1:25 p.m. and RN CC at 12:33

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p.m.

The following Certified Nursing Assistants (CNA) were interviewed on 2/4/19, confirming they had attended in-services on 1/29/19 related to Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: CNA II at 12:27 p.m., CNA JJ at 12:29 p.m., CNA MM and CNA NN at 12:36 p.m., CNA OO at 12:39 p.m., CNA QQ at 12:47 p.m., CNA TT and CNA SS at 12:51 p.m., CNA UU at 12:53 p.m., CNA YY at 1:04 p.m., CNA AAA and CNA BBB at 1:09 p.m., CNA CCC at 1:12 p.m. and CNA GGG at 12:21 p.m.

The following interviews were conducted on 2/4/19 related to in-services on 1/29/19 confirming they had attended in-services on Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: Admission Coordinator LL at 12:34 p.m., Activity Director XX at 1:00 p.m., Social Worker DDD at 1:12 p.m., Front office staff EEE and FFF at 1:18 p.m., Maintenance staff JJJ and KKK at 1:34 p.m., Dietary Aides LLL and MMM at 1:40 p.m., Cooks NNN and OOO at 1:43 p.m., Housekeeping Staff PPP and QQQ at 1:48 p.m. and Housekeeping staff RRR and SSS at 1:50 p.m. and Laundry staff TTT at 1:54 p.m.

3. The Advanced Directive Policy was reviewed and signed by the Administrator on 1/29/19 and verified with an interview on 2/4/19 at 2:32 p.m. with the Administrator.

4. Verified via interview 2/4/19 at 12:33 p.m. with CCC CC, interview 2/4/19 at 1:15 p.m. with the DHS and review of audit documentation and completed Advance Directive checklists. Also verified via interview 2/4/19 at 2:32 p.m. with the

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	Administrator who stated she had actually been auditing the lists twice daily. 5. Verified via interview 2/4/19 at 1:15 p.m. with the DHS confirming that the audit findings will be communicated at the QAPI meetings monthly.			
F 0695 SS= D	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Physician's Order for the use of oxygen for one resident (#4) from a total sample of 30 residents. Findings include: Resident (R) #4 was admitted to the facility on 12/3/18 with diagnoses that included acute on chronic systolic heart failure, atherosclerotic heart disease, difficulty walking, muscle weakness, dysphagia, ischemic cardiomyopathy, hypertension, hyperlipidemia, type 2 diabetes, and chronic kidney disease. In addition, progress notes documented the resident was status post a fall and left eye surgery, prior to admission. A care plan was developed on 12/3/18 for oxygen use with an intervention for nursing staff to apply oxygen as ordered.	F 0695		

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	A review of the clinical record, including progress notes and vitals report revealed that oxygen was in use at two liters per minute for R#4 on 12/4/18, 12/8/18, 12/12/18, 12/14/18, 12/15/18 and 12/17/18. However, further review of the clinical record revealed no Physician's Order for the use of oxygen. During an interview on 1/29/19 at 9:15 a.m., the Administrator confirmed that the resident did not have a Physician's Order for the use of oxygen.			
F 0760 SS= D	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that one resident (#11) from free from medication errors from a total sample of 30 residents. Findings include: Resident #11 was admitted to the facility on 11/23/18. A review of the Admission orders revealed Physician's Orders for two eye medications, Lumigan and levobunolol. One drop of levobunolol 0.25% opthalmic solution was ordered to be administered twice daily to both eyes. One drop of Lumigan 0.01% opthalmic solution was ordered to be administered daily, at bedtime. A review of the clinical record, including the Medication Administration Record (MAR) revealed that the 9:00 a.m. and 9:00 p.m. doses	F 0760		

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	of levobunolol were not administered as ordered on 11/24/18, with documentation that the medication was unavailable. In addition, the 9:00 p.m. doses of Lumigan were not administered as ordered on 11/24/18 and 11/25/18, with documentation that the medication was unavailable. During an interview on 1/31/19 at 12:05 p.m. Licensed Practical Nurse (LPN) FF stated that when medications arrive from the pharmacy, they come to the nursing station and the nurses sign for them and add them to the medication carts. She also stated that if she documented the medications were not available, then that meant she did not have the medications to give. If she had them, she would have administered the medications as ordered. However, during an interview on 1/31/19 at 11:23 a.m., Pharmacist EE stated that the eye medications were filled on 11/24/18 and delivered to the facility that same day, around 5:00 p.m.			
F 0835 SS= J	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Administrator "Job Description" and staff interviews, it was determined the facility administration failed to ensure effective monitoring of the Advance Directive system to include accurate code status was available in the electronic record for two residents (R) (#4 and #12) and failed to verify that the Advanced Health Care Directive was available, at the facility, and in the electronic record before declaring one resident (#12) a Do Not	F 0835		

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Resuscitate (DNR) from a total sample of 30 residents.

An Abbreviated/Partial Extended Survey investigating complaints GA00192836, GA00192960, GA00193577, GA00193661 and GA00193672 was initiated on January 2, 2019 and concluded on January 3, 2019. Complaints GA00192836, GA00192960, GA00193577, and GA00193661 were unsubstantiated. After review by the State Survey Agency, further investigation was needed for complaint GA00193672, and a re-entry was initiated on January 28, 2019 and concluded on February 4, 2019. An additional complaint, GA00194099 was also investigated. Complaint GA00193672 was substantiated with deficiencies. Complaint GA00194099 was partially substantiated with deficiencies. As indicated on the facility's Form CMS-672, Resident Census and Conditions of Resident Form, the facility's census on January 3, 2019 was 83.

On January 29, 2019, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents.

The facility's Administrator, Nurse Consultant UUU, and Area Vice President were informed of the Immediate Jeopardy on January 29, 2019 at 4:15 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 19, 2018. The Immediate Jeopardy continued through January 29, 2019 and was removed on January 30, 2019.

The Immediate Jeopardy is outlined as follows:

1. Resident (R) #4 had not executed an Advance Directive. On December 19, 2018, R#4

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	was found in bed, unresponsive, with no vital signs. The resident's Advance Directive status was initially inaccurately assessed by licensed nursing staff as Do Not Resuscitate (DNR) in the electronic record, therefore, no emergency basic life support was immediately provided. The Physician and the Director of Health Services (DHS) were notified. While documenting the incident on a Situation, Background, Assessment, Recommendation (SBAR) form in the resident's clinical record the Licensed staff discovered that the resident had a full code status rather than a DNR status. Licensed nursing staff identified the error of the incorrect Advance Directive status approximately one hour after initially finding the resident unresponsive, at which time, the DHS initiated Cardiopulmonary Resuscitation (CPR) and Emergency Medical Services (EMS) were notified. EMS arrived and continued to provide additional emergency support. However, basic life support measures were not successful, and the DHS pronounced R#4's death on December 19, 2018 at 6:53 a.m. 2. R#12 experienced a change in condition on January 5, 2019. The resident was found in bed, unresponsive to all stimuli and without vital signs. The resident's Advance Directive status was listed in the electronic clinical record as DNR, therefore, licensed nursing staff did not provide emergency basic life support measures and R#12's death was pronounced at the facility on January 5, 2019 at 2:45 p.m. However, the DNR status in the clinical record was inaccurate. There was no supporting Physician's Order or signed DNR documentation to support the DNR status listed in the resident's clinical record. Immediate Jeopardy was identified on January 29, 2019 and determined to exist on December 19, 2018 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F655; 42 CFR: 483.21 (v)(3)(i) Services Provided Meet Professional Standards, F658; 42 CFR: 483.24 (a)(3) Cardio-Pulmonary			

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	1-075-1648	A. BUILDING B. WING	02/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Resuscitation (CPR), F678; 42 CFR 483.70 Administration, F835; 42 CFR: 483.20 (f)(5), 483.70 (i)(1)-(5) Resident Records-Identifiable Information, F842; 42 CFR 483.75(d) Quality Assurance and Performance Improvement Activities, F867, all at a Scope and Severity (S/S) of a "J".

Additionally, Substandard Quality of Care was identified at 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678.

A Credible Allegation of Compliance was received on January 29, 2019. Based on interviews, record reviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 29, 2019. The facility remained out of compliance at a lower scope and severity of "D" while the facility continued management level staff oversight of the Advance Directive system and continued education. This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures.

Findings include:

The facility had a "Job Description" for the job title of Administrator. The description included that the purpose of the job was to direct the day-to-day functions of the nursing center in accordance with federal, state, and local regulations that govern long-term care centers, and as may be directed by the Area Vice President, to provide appropriate care for residents. The position description also included a key responsibility of the ability to apply standards of professional practice to operations of the nursing facility and to establish criteria to assure that care provided meets established standards of quality.

The facility had an "Advance Directive: Georgia" policy and "Do Not Resuscitate Policy: Georgia" policy in place to address obtaining and maintaining resident Advance Directive documentation in the clinical record. In addition, the facility began using an electronic charting system 11/1/18. However, there was no evidence that the Advance Directive system was routinely monitored by the Administrator, to ensure that it was accurately and consistently implemented.

During an interview on 1/31/19 at 1:50 p.m., the Administrator stated that she was notified of R#4's death on 12/19/18. In response to the incident, she interviewed staff, called a QAPI meeting (on 12/19/18), put a plan in place and began auditing residents' advance directive status in the clinical records. A review of the plan revealed that it included the following specifics:

The facility identified that all residents had the potential to be affected.

A. The DHS and Assistant Director of Health Services (ADHS) would educate all nurses on the Advance Directives policy and procedures. All nurses would also be educated on the Matrix (the facility's electronic clinical record system) integration related to Advance Directives. All training was initiated on 12/19/18 and would be completed by 12/21/18 with all nurses being educated prior to the start of their next shift.

B. The Administrator or designee would complete a daily audit tool to monitor advance directives for four weeks. The DHS and ADHS would complete a weekly audit tool to monitor compliance for four weeks. A QAPI committee meeting would be held on 1/17/19 to ensure the audit was correct and that no other issues were

identified.

However, despite the facility's implemented interventions to ensure the Advance Directives were integrated into the electronic clinical record, they failed to ensure that the Advance Directives status was accurate with supporting advance directive documentation.

During an interview on 1/31/19 at 1:50 p.m., the Administrator confirmed that she was not aware of any concerns regarding advance directive completion and accuracy in the clinical record prior to R#4's and R#12's deaths. Further interview revealed that she stated she was not aware the supporting documents were not available to confirm the DNR status that had been entered in R#12's electronic record. She stated that she was only checking the code reports with the banner in the electronic records to ensure the correct code status was in the banner. She stated she was not verifying the supporting documents, such as Advanced Health Directives, were in the electronic record to support a DNR status. At this time, the Administrator revealed that the new electronic medical system was begun on 11/1/18 and that staff were in-serviced on how to use the new system on 11/13/18 and 11/14/18 as the specific systems went online. The Administrator supplied the training agenda and sign in sheets for the 11/14/18 in-service which covered Resident Charting, Resident Banner items, Entering documentation for the DHS, Nurse Leaders and Nurses. Licensed Practical Nurse (LPN) AA was present and signed in for the in-service.

The facility implemented the following actions to remove the Immediate Jeopardy:

Facility must be administered in a manner that enables it to use its resources effectively and efficiently to maintain the highest practical

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	1-075-1648	A. BUILDING B. WING	**02/04/2019**

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	physical and psychosocial wellbeing of each Resident. Root Cause Analysis Facility failed to identify supporting documentation for Advanced Directives. This Immediate Jeopardy was abated on 01/30/19, at which time the facility completed the following actions. 1) Current Resident's now have supporting documentation in the electronic medical record for their Advanced Directive. 2) The Director of Health Services and or Unit Manager will monitor this process in clinical stand-up by reviewing all new orders and assuring any DNR or Full Code orders are in the electronic medical record and the banner is correct. This process will be documented on the Advance Directives Checklist by the Director of Health Services or Unit Manager. 3) Senior Nurse Consultant provided training to the facility Administrator on the Advanced Directives policy on 01/29/2019. The Administrator was educated on 8/14/18 by the AVP on the Administrator job description and responsibilities. 4) The facilities policy has been reviewed and is current. The policy was reviewed on 01/29/2019. 5) Results will be communicated by the Director of Health Services or Administrator at QAPI monthly x3 months.			

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	The State Survey Agency (SSA) validated the facility's Credible Allegation of Immediate Jeopardy Removal as follows: 1. Review of residents on the resident census list and supporting documentation for those residents specified as having a DNR status confirmed that the status and supporting documentation was correct. 2. An interview with the DHS and LPN PP, Unit Manager, on 2/4/19 at 1:15 p.m. confirmed that all new orders are reviewed during clinical stand-up meeting and assured that any DNR or Full Code Status are in the electronic medical record and that the banner reading is correct. Review of the Advanced Directives Checklist was reviewed to confirm the DHS or Unit Manager are completing the form. 3. Review of the Administrator education form dated 1/29/19 confirmed that the Senior Nurse Consultant provided training on Advanced Directives policy and was signed by the Administrator to ensure understanding. 4. Review of the facilities policy revealed a review date of 1/29/19 and is current. 5. An interview with the DHS on 2/4/19 at 1:15 p.m. confirmed that the results of the clinical stand-up meeting and the Advanced Directives Checklist will be reviewed during the monthly QAPI meetings.			
F 0842 SS= J	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 0842		

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	(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard			

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	medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure the Advance Directive status was accurately reflected on the electronic record face sheet, physician's orders and the Medication Administration Record (MAR) for two residents(R) (#4 and #12), from a total sample of 30 residents. An Abbreviated/Partial Extended Survey investigating complaints GA00192836, GA00192960, GA00193577, GA00193661 and GA00193672 was initiated on January 2, 2019			

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	and concluded on January 3, 2019. Complaints GA00192836, GA00192960, GA00193577, and GA00193661 were unsubstantiated. After review by the State Survey Agency, further investigation was needed for complaint GA00193672, and a re-entry was initiated on January 28, 2019 and concluded on February 4, 2019. An additional complaint, GA00194099 was also investigated. Complaint GA00193672 was substantiated with deficiencies. Complaint GA00194099 was partially substantiated with deficiencies. As indicated on the facility's Form CMS-672, Resident Census and Conditions of Resident Form, the facility's census on January 3, 2019 was 83. On January 29, 2019, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Nurse Consultant UUU, and Area Vice President were informed of the Immediate Jeopardy on January 29, 2019 at 4:15 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 19, 2018. The Immediate Jeopardy continued through January 29, 2019 and was removed on January 30, 2019. The Immediate Jeopardy is outlined as follows: 1. Resident (R) #4 had not executed an Advance Directive. On December 19, 2018, R#4 was found in bed, unresponsive, with no vital signs. The resident's Advance Directive status was initially inaccurately assessed by licensed nursing staff as Do Not Resuscitate (DNR) in the electronic record, therefore, no emergency basic life support was immediately provided. The Physician and the Director of Health Services (DHS) were notified. While			

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	documenting the incident on a Situation, Background, Assessment, Recommendation (SBAR) form in the resident's clinical record the Licensed staff discovered that the resident had a full code status rather than a DNR status. Licensed nursing staff identified the error of the incorrect Advance Directive status approximately one hour after initially finding the resident unresponsive, at which time, the DHS initiated Cardiopulmonary Resuscitation (CPR) and Emergency Medical Services (EMS) were notified. EMS arrived and continued to provide additional emergency support. However, basic life support measures were not successful, and the DHS pronounced R#4's death on December 19, 2018 at 6:53 a.m. 2. R#12 experienced a change in condition on January 5, 2019. The resident was found in bed, unresponsive to all stimuli and without vital signs. The resident's Advance Directive status was listed in the electronic clinical record as DNR, therefore, licensed nursing staff did not provide emergency basic life support measures and R#12's death was pronounced at the facility on January 5, 2019 at 2:45 p.m. However, the DNR status in the clinical record was inaccurate. There was no supporting Physician's Order or signed DNR documentation to support the DNR status listed in the resident's clinical record. Immediate Jeopardy was identified on January 29, 2019 and determined to exist on December 19, 2018 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F655; 42 CFR: 483.21 (v)(3)(i) Services Provided Meet Professional Standards, F658; 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678; 42 CFR 483.70 Administration, F835; 42 CFR: 483.20 (f)(5), 483.70 (i)(1)-(5) Resident Records-Identifiable Information, F842; 42 CFR 483.75(d) Quality Assurance and Performance Improvement Activities, F867, all at a Scope and Severity (S/S) of a "J".			

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Additionally, Substandard Quality of Care was identified at 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678.

A Credible Allegation of Compliance was received on January 29, 2019. Based on interviews, record reviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 29, 2019. The facility remained out of compliance at a lower scope and severity of "D" while the facility continued management level staff oversight of the Advance Directive system and continued education. This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures.

Findings include:

The facility had a "Records Management" policy. The policy included that it was the facility's policy to apply effective and cost-efficient management techniques to maintain complete and accurate records.

The facility had an "Advance Directive: Georgia" policy and "Do Not Resuscitate Policy: Georgia" policy in place to address obtaining and maintaining resident Advance Directive documentation in the clinical record. In addition, the facility began using an electronic charting system 11/1/18.

Review of the Administrator's interview with Licensed Practical Nurse (LPN) XXX, who was assisting LPN AA, dated 12/19/18 revealed that when reviewing the new electronic record "banner" for R#4 when she was found unresponsive and without vital signs, the banner contained no Advanced Directive Status. She stated that as a result, LPN AA determined R#4

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to be a No Code and did not begin CPR.

A post survey interview with the DHS and the Administrator on 1/15/19 at 11:50 a.m. revealed that R#4's Code Status was not in the "banner" of the new electronic record, but should have been. The nurses had been trained to look at the "banner" for the resident's Code Status although if there was no information then it should be assumed that the resident is a full code.

During an interview on 1/31/19 at 1:50 p.m., the Administrator stated that she was notified of R#4's death on 12/19/18. Further interview the Administrator confirmed that she was not aware of any concerns regarding advance directive completion and accuracy in the clinical record prior to R#4's and R#12's deaths. In response to the incident, she interviewed staff, called a Quality Assurance Performance Improvement (QAPI) meeting (on 12/19/18), put a plan in place and began auditing residents' advance directive status in the clinical records. A review of the plan revealed that it included the following specifics:

The facility identified that all residents had the potential to be affected.

A. The DHS and Assistant Director of Health Services (ADHS) would educate all nurses on the Advance Directives policy and procedures. All nurses would also be educated on the Matrix (the facility's electronic clinical record system) integration related to Advance Directives. All training was initiated on 12/19/18 and would be completed by 12/21/18 with all nurses being educated prior to the start of their next shift.

B. The Administrator or designee would complete a daily audit tool to monitor advance directives for four weeks. The DHS and ADHS

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would complete a weekly audit tool to monitor compliance for four weeks. A QAPI committee meeting would be held on 1/17/19 to ensure the audit was correct and that no other issues were identified.

However, despite the facility's implemented interventions to ensure the Advance Directives were integrated into the electronic clinical record, they failed to ensure that the Advance Directives status was accurate with supporting Advance Directive documentation.

Cross refer to F678

The facility implemented the following actions to remove the Immediate Jeopardy:

Facility must maintain medical record on each resident that is complete, accurate and readily assessible.

Root Cause Analysis

Facility failed to maintain Resident's code status in their medical record for Resident #4 and Resident #12.

This Immediate Jeopardy was abated on 01/30/19, at which time the facility has completed the following actions:

1) The admitting nurse is responsible for maintaining accurate information.

2) Director of Health System and Administrator completed an audit of all active resident records on 01/29/19 to ensure the medical record is

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complete, accurate and readily assessible.

3) All staff were educated on 01/29/19. As of 01/30/19 we have trained 2/2 activity (100%), 2/2 Maintenance (100%), Administration 7/7 (100%), Housekeeping & Laundry 11/11 (100%), Dietary 7/10 (70%), Certified Nursing Assistant 25/31 (81), Licensed Practical Nurses 14/16 (88%), Registered Nurses 11/11 (100%), Therapist 15/20 (75%) by the Director of Health Services and the Clinical Competency Coordinator to verify code status via Resident chart. Staff that have not been trained as of 01/30/2019 will be trained prior to working their next shift. All new hires will be trained during orientation on maintaining the medical record on each resident that is complete, accurate and readily assessible.

4) The facilities policy has been reviewed and is current. The policy was reviewed on 01/29/2019.

5) The Director of Health Services and or Unit Manager will monitor this process in clinical stand-up by reviewing all new orders and assuring any Do Not Resuscitate or Full Code orders are in the electronic medical record and the banner is correct. This process will be documented on the Advance Directives Checklist by the DHS or Unit Manager.

6) Results will be communicated by the Director of Health Services or Administrator at Quality Assurance Performance Improvement monthly x3 months.

The State Survey Agency (SSA) validated the facility's Credible Allegation of Immediate Jeopardy Removal as follows:

1. This process was confirmed during an

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interview with Assistant Director of Health Services (ADHS) on 2/4/19 at 12:53 p.m. and during an interview with the Administrator on 2/4/19 at 2:32 p.m.

2. Review of the Audit documentation and completed Advanced Directives Checklist verified this process is being done. An interview with the Administrator on 2/4/19 at 2:32 p.m. verified that all information inputted to the electronic record is accurate. The Administrator revealed that one resident had changed their Advanced Directive and were able to use the new system to ensure that the change was completed accurately.

3. The following interviews revealed that all of the staff were able to describe the in-service training for the Advance Directives, Code Status and care planning for Code Status. They stated they have had three to four classes on the topics and then a refresher was done every day where the management would come ask them questions and some had to do a return demonstration to make sure they understood. They were able to describe where to find the resident's Code Status, the banner and in resident electronic documents. They also stated if there was no Code Status on the banner or the documents that the resident would be full code and they would have to start CPR. They stated the resident would be a full code until the proper documents were provided. They also discussed the care plans, where the Code Status would also be included.

The following interviews were conducted on 2/4/19 with Licensed Practical Nurses (LPN) confirming they have attended in-services on 1/29/19 related to Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: LPN HH at 12:27 p.m., LPN PP, Unit Manager, at 12:39 p.m.,

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	LPN RR at 12:47 p.m. and LPN WW at 1:00 p.m. The following Registered Nurses (RN) were interviewed on 2/4/19 confirming attending in-services regarding the Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status on 1/29/19: RN KK at 12:29 p.m., RN DD at 12:34 p.m., RN SS at 12:51 p.m., RN VV (Assistant Director Health Services-ADHS) at 12:53 p.m., RN ZZ at 1:04 p.m., RN HHH (DHS) at 1:21 p.m., RN III at 1:25 p.m. and RN CC at 12:33 p.m. The following Certified Nursing Assistants (CNA) were interviewed on 2/4/19, confirming they had attended in-services on 1/29/19 related to Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: CNA II at 12:27 p.m., CNA JJ at 12:29 p.m., CNA MM and CNA NN at 12:36 p.m., CNA OO at 12:39 p.m., CNA QQ at 12:47 p.m., CNA TT and CNA SS at 12:51 p.m., CNA UU at 12:53 p.m., CNA YY at 1:04 p.m., CNA AAA and CNA BBB at 1:09 p.m., CNA CCC at 1:12 p.m. and CNA GGG at 12:21 p.m. The following interviews were conducted on 2/4/19 related to in-services on 1/29/19 confirming they had attended in-services on Advanced Directives Policy, responsibilities for maintaining the resident's record and confirming the Code Status in the electronic record and to confirm the accuracy of the resident's code status: Admission Coordinator LL at 12:34 p.m., Activity Director XX at 1:00 p.m., Social Worker DDD at 1:12 p.m., Front office staff EEE and FFF at 1:18 p.m., Maintenance staff JJJ and KKK at 1:34 p.m., Dietary Aides LLL and MMM at 1:40 p.m., Cooks NNN and OOO at 1:43			

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	p.m., Housekeeping Staff PPP and QQQ at 1:48 p.m. and Housekeeping staff RRR and SSS at 1:50 p.m. and Laundry staff TTT at 1:54 p.m. 4. Review and interview with the Administrator on 2/4/19 on 2:32 p.m. of the Records Management policy revealed the Administrator had signed the policy on 1/29/19. 5. An interview with the DHS and LPN PP, Unit Manager, on 2/4/19 at 1:15 p.m. confirmed that all new orders are reviewed during clinical stand-up meeting and assured that any DNR or Full Code Status are in the electronic medical record and that the banner reading is correct. Review of the Advanced Directives Checklist was reviewed to confirm the DHS or Unit Manager are completing the form. 6. An interview with the DHS on 2/4/19 at 1:15 p.m. confirmed that the results of the clinical stand-up meeting and the Advanced Directives Checklist will be reviewed during the monthly QAPI meetings.			
F 0867 SS= J	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews and policy review, the facility failed to utilize the Quality Assurance and Performance Improvement (QAPI) system to oversee the Advance Directive system, to ensure advance directive documentation was maintained and	F 0867		

accurate in the clinical record, in an effort to prevent errors or delays in emergency basic life support measures. The facility had a census of 86 residents.

An Abbreviated/Partial Extended Survey investigating complaints GA00192836, GA00192960, GA00193577, GA00193661 and GA00193672 was initiated on January 2, 2019 and concluded on January 3, 2019. Complaints GA00192836, GA00192960, GA00193577, and GA00193661 were unsubstantiated. After review by the State Survey Agency, further investigation was needed for complaint GA00193672, and a re-entry was initiated on January 28, 2019 and concluded on February 4, 2019. An additional complaint, GA00194099 was also investigated. Complaint GA00193672 was substantiated with deficiencies. Complaint GA00194099 was partially substantiated with deficiencies. As indicated on the facility's Form CMS-672, Resident Census and Conditions of Resident Form, the facility's census on January 3, 2019 was 83.

On January 29, 2019, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents.

The facility's Administrator, Nurse Consultant UUU, and Area Vice President were informed of the Immediate Jeopardy on January 29, 2019 at 4:15 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 19, 2018. The Immediate Jeopardy continued through January 29, 2019 and was removed on January 30, 2019.

The Immediate Jeopardy is outlined as follows:

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	1. Resident (R) #4 had not executed an Advance Directive. On December 19, 2018, R#4 was found in bed, unresponsive, with no vital signs. The resident's Advance Directive status was initially inaccurately assessed by licensed nursing staff as Do Not Resuscitate (DNR) in the electronic record, therefore, no emergency basic life support was immediately provided. The Physician and the Director of Health Services (DHS) were notified. While documenting the incident on a Situation, Background, Assessment, Recommendation (SBAR) form in the resident's clinical record the Licensed staff discovered that the resident had a full code status rather than a DNR status. Licensed nursing staff identified the error of the incorrect Advance Directive status approximately one hour after initially finding the resident unresponsive, at which time, the DHS initiated Cardiopulmonary Resuscitation (CPR) and Emergency Medical Services (EMS) were notified. EMS arrived and continued to provide additional emergency support. However, basic life support measures were not successful, and the DHS pronounced R#4's death on December 19, 2018 at 6:53 a.m. 2. R#12 experienced a change in condition on January 5, 2019. The resident was found in bed, unresponsive to all stimuli and without vital signs. The resident's Advance Directive status was listed in the electronic clinical record as DNR, therefore, licensed nursing staff did not provide emergency basic life support measures and R#12's death was pronounced at the facility on January 5, 2019 at 2:45 p.m. However, the DNR status in the clinical record was inaccurate. There was no supporting Physician's Order or signed DNR documentation to support the DNR status listed in the resident's clinical record. Immediate Jeopardy was identified on January 29, 2019 and determined to exist on December 19, 2018 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F655; 42 CFR: 483.21 (v)(3)(i) Services			

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	1-075-1648	A. BUILDING B. WING	02/04/2019

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Provided Meet Professional Standards, F658; 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678; 42 CFR 483.70 Administration, F835; 42 CFR: 483.20 (f)(5), 483.70 (i)(1)-(5) Resident Records-Identifiable Information, F842; 42 CFR 483.75(d) Quality Assurance and Performance Improvement Activities, F867, all at a Scope and Severity (S/S) of a "J".

Additionally, Substandard Quality of Care was identified at 42 CFR: 483.24 (a)(3) Cardio-Pulmonary Resuscitation (CPR), F678.

A Credible Allegation of Compliance was received on January 29, 2019. Based on interviews, record reviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 29, 2019. The facility remained out of compliance at a lower scope and severity of "D" while the facility continued management level staff oversight of the Advance Directive system and continued education. This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures.

Findings include:

The facility had a "Quality Assurance and Performance Improvement" policy. The policy documented that the purpose of the Quality Assurance and Performance Improvement (QAPI) program was to continually take a proactive approach to assure and improve the way the facility provided are and engage with patients, partners, and other stakeholders so that the facility may fully realize their vision, mission and commitment to caring pledge.

During an interview on 1/31/19 at 1:50 p.m., the

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Administrator revealed that she oversees the QAPI committee and they met on a monthly basis, on the third Wednesday of each month.

The facility had an "Advance Directive: Georgia" policy and "Do Not Resuscitate Policy: Georgia" policy in place to address obtaining and maintaining resident Advance Directive information in the clinical record. However, there was no evidence that this system was routinely monitored through the QAPI process, to ensure that it was accurately and consistently implemented.

During an interview on 1/31/19 at 1:50 p.m., the Administrator stated that she was notified of R#4's death on 12/19/18. Further interview the Administrator confirmed that she was not aware of any concerns regarding Advance Directive completion and accuracy in the clinical record prior to R#4's and R#12's deaths. In response to the incident, she interviewed staff, called a Quality Assurance Performance Improvement (QAPI) meeting (on 12/19/18), put a plan in place and began auditing residents' Advance Directive status in the clinical records. A review of the plan revealed that it included the following specifics:

The facility identified that all residents had the potential to be affected.

1. The DHS and Assistant Director of Health Services (ADHS) would educate all nurses on the Advance Directives policy and procedures. All nurses would also be educated on the facility's electronic clinical record system integration related to Advance Directives. All training was initiated on 12/19/18 and would be completed by 12/21/18 with all nurses being educated prior to the start of their next shift.

2. The Administrator or designee would

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complete a daily audit tool to monitor advance directives for four weeks. The DHS and ADHS would complete a weekly audit tool to monitor compliance for four weeks. A QAPI committee meeting would be held on 1/17/19 to ensure the audit was correct and that no other issues were identified.

However, despite the facility's implemented interventions to ensure the Advance Directives were integrated into the electronic clinical record, they failed to ensure that the Advance Directives status was accurate with supporting Advance Directive documentation.

Cross refer to F678

The facility implemented the following actions to remove the Immediate Jeopardy. During Post survey review it was determined that the deficiency should be cited under F687:

Facility must maintain a Quality Assurance Performance Improvement committee consisting of the Director of Health Services, Medical Director, Infection Prevention Committee, Administrator must meet quarterly to evaluate activities under the Quality Assurance Performance Improvement program.

Root Cause Analysis

Facility failed to identify the Advanced Directives on Resident #4 and Resident #12.

1) On January 29, 2019 the Facility Administrator, Director of Health Services, Area Vice President, Senior Nurse Consultant, Assistant Director of Health Services, Unit Manager, MDS Coordinators, Housekeeping and Laundry Director, Social Services Director,

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Activities Director, Admissions Director, Admissions Coordinator, Clinical Competency Coordinator (CCC), Business Office Manager, Human Resources, Medical Records Coordinator, Senior Care Partner, Therapy Director, Wound Nurse (SNC) met in facility conference for immediate Quality Assurance Performance Improvement interventions to the cited incident. The Medical Director participated via phone for the Quality Assurance Performance Improvement and concurred with initial self-imposed interventions as detailed in the below AOC.

2) The facilities policy has been reviewed and is current. The policy was reviewed on 01/29/2019.

3) Director of Health Services and Social Services completed an audit of all active resident records on 01/29/19 to ensure the Resident's Advanced Directives were in the medical records.

4) The Advanced Directive Clinical system checklist will be updated daily upon each new admission or change in Advanced Directives orders by DHS, unit managers or Social Worker. The Advance Directive auditing will be on-going.

5) Education compliance related to F655, F658, F678, F835, F842 and F868 (during QA review the deficiency was changed to F867) will be reported to Quality Assurance Performance Improvement by the Clinical Competency Coordinator monthly x3 months and quarterly thereafter as needed. All new staff hired will be educated on Advanced Directives in orientation.

Title of Person Responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing the acceptable plan of correction.

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	The State Survey Agency (SSA) validated the facility's Credible Allegation of Immediate Jeopardy Removal as follows: 1. Review of the sign in sheets of the 1/29/19 QAPI meeting confirmed the attendance of full committee. The Medical Director attended via telephone. Interviews were conducted on 2/4/19 at 12:33 p.m. with Clinical Competency Coordinator (CCC) CC, at 1:10 p.m. with the Human Resource (HR) Director and Financial Director, with the DHS at 1:15 p.m., with the Maintenance Director at 1:34 p.m., and with the Housekeeping supervisor at 1:50 p.m. confirming their attendance for the 1/29/19 QAPI meeting. 2. Review of the QA policy which was signed as reviewed by the Administrator on 1/29/19. An interview with the Administrator on 2/4/19 at 2:32 p.m. to review the policy and confirmed that the policy was reviewed and approved by the QAPI members, then signed by the Administrator on 1/29/19. 3. Review of the audit documentation and interview with the DHS on 2/4/19 at 1:15 p.m. verified the audit of all active resident records to confirm Advanced Directives were in the medical records. 4. Interviews on 2/4/19 at 1:15 p.m. with the DHS and ADHS verified the daily audit and update of Advanced Directives for new admissions or residents with a change in condition. 5. An interview with CCC CC on 2/4/19 at 12:33 p.m. verified that education has been completed and the results will be reported to the QAPI meetings, monthly and quarterly thereafter. She			

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	confirmed that all new staff hired will be educated upon hire. The facility has had no new hires since 1/29/19. An interview with the Administrator on 2/4/19 at 2:32 p.m. verified that she was responsible for implementing the acceptable plan of correction. She also stated that since the AOC had been written, 100% of staff had now been in-serviced. The QAPI committee had also had additional meetings on 1/31/19 and 2/1/19 to review the ongoing process (verified via review of sign-in sheets).			