STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185442		C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART VILLAGE	2120 PAYNE STREET LOUISVILLE, KY 40206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey was initiated on 02/01/12 and concluded on 02/03/12 investigating KY #17778. The complaint was substantiated. Immediate Jeopardy was identified on 02/02/12 at 42 CFR 483.20 Resident Assessment (F281 S/S "J"). Resident #1 had a physician's order dated 01/24/12 through 01/31/12 with a Code Status of Full Code. On 01/26/12 Resident #1 was last seen alive at 4:30 AM and was discovered without pulse or respirations at 5:30 AM when Licensed Practical Nurse (LPN) #5 entered the room to administer the morning medications. The nurse did not initiate CPR and left the room to report to the house supervisor on duty of the resident expiring. The supervisor and the LPN did not know Resident #1's code status and did not check the medical record to ascertain that information. The Executive Director (ED) was contacted for direction and the staff was informed to call the Emergency Medical Services (EMS). The ED did not instruct the staff to initiate CPR and CPR was not initiated as the resident had wished. EMS personnel was called and pronounced Resident #1 deceased at 5:40 AM. Immediate Jeopardy was determined to exist on 01/26/12 through 01/29/12. It was determined the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 02/01/12, thus resulting in the determination of Past Jeopardy. The Jeopardy was determined to be removed on 01/30/12.	F 000		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy titled "Emergency or Acute Treatment", it was determined the facility failed to meet professional standards of quality for one (1) of six (6) sampled residents (Resident #1) and four (4) unsampled residents. The facility failed to provide a Full Code (to include Cardiopulmonary Resuscitation [CPR]) per Resident #1's wishes in an Advance Directive, failed to follow a physician's order for a Full Code, and failed to follow it's policy on Emergency or Acute Treatment. On 01/26/12 Resident #1 was last seen alive at 4:30 AM and was discovered without pulse or respirations at 5:30 AM when Licensed Practical Nurse (LPN) #5 entered the room to administer the morning medications. The nurse did not initiate CPR and left the room to report to the house supervisor on duty of the resident expiring. The supervisor and the LPN did not know the code status of the resident and did not check the medical record to ascertain that information. The Executive Director (ED) was contacted for direction and the staff was informed to call Emergency Medical Services (EMS). The ED did not instruct the staff to initiate CPR and CPR was not initiated as the resident had wished. EMS was called and pronounced Resident #1 deceased at 5:40 AM. The failure to provide a Full code per a resident's	F 281	Past noncompliance: no plan of correction required.	

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F 281	Continued From page 2 Advanced Directive has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. The Immediate Jeopardy was determined to exist on 01/26/12 through 01/29/12. The facility implemented corrective actions which were completed prior to the State Agency's investigation on 02/01/12, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be removed on 01/30/12. The findings include: Review of the facility's policy entitled "Emergency or Acute Treatment" (dated 02/13/09) revealed the following procedure: A nurse will establish the residents DPOAHC (Durable Power of Attorney Health Care [Advance Directive]) prior wishes for emergency and treatment of acute change in conditions. If after assessment immediate intervention is indicated, it is initiated, i.e., cardiopulmonary resuscitation (CPR), suctioning. . . ,etc. The nurse would note the resident's physician orders (i.e., resuscitation decisions) PRIOR to initiating emergency care. If CPR is initiated, 911 is contacted immediately. The physician is contacted and updated on the resident's condition. The physician determines any need for transfer, with the order given, except in the instance of cardiac or respiratory arrest, when the resident is transferred as soon as possible. All residents are to be resuscitated, unless there is evidence for alternate treatment decisions expressed. Closed record review for Resident #1 revealed the facility admitted the resident on 01/24/12 with diagnoses to include Severe Chronic Obstructive	F 281		

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F 281	Continued From page 3 Pulmonary Disease and Dementia. Further record review for Resident #1 revealed an Advance Directive form signed by the resident and dated 01/24/12 indicated the resident did not elect to have massage (cardiac) or artificial resuscitation withheld in the event of respiratory failure or cardiac arrest. Further review of Resident #1's record revealed a physician's order dated 01/24/12 through 01/31/12, Code Status: Full Code. Review of Resident #1's nurses notes, dated 01/26/12, revealed the resident was seen alive on 01/26/12 at 4:30 AM and was discovered without pulse or respirations at 5:30 AM. The nursing notes further revealed Emergency Medical Services (EMS) personnel were present and pronounced Resident #1 deceased at 5:40 AM. Interview with LPN #5, on 02/02/12 at 4:00 PM, revealed she did not initiate CPR or call a Code on Resident #1 when she found the resident, on 01/26/12 at 5:30 AM, without a pulse or respirations. She stated Resident #1 was gray in color, had no respirations and no pulse, did not show any signs of life, and she assessed the resident as "clearly deceased". LPN #5 stated she notified the Registered Nurse (RN) Supervisor at approximately 5:30 AM on 01/26/12 about the resident's death, but when asked by the Nurse Supervisor if the resident was a Full Code, she answered she did not know. However, the LPN stated she knew the code status was located in the physician orders as well as the advanced directive. Interview with the RN Supervisor, on 02/03/12 at 1:00 PM, who was on duty the night of Resident #1's death, revealed she assumed Resident #1	F 281		

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F 281	Continued From page 4 was a Do Not Resuscitate, because LPN #5 did not call a Code. She inquired of the code status after the assessment of the resident. In addition, the RN was aware the code status could be located by checking the physician orders or the advanced directive in the clinical record. The RN Supervisor indicated she did call the Executive Director (ED) at 5:43 AM when she became aware the resident was a Full Code to ask if she should call 911, but she did not ask the ED if the resident should have CPR initiated. She stated she relied on the ED to give her direction regarding the initiation of CPR on Resident #1. She further stated she was the weekend supervisor at the facility and had never been in a situation like the one with Resident #1. Interview with the ED, on 02/03/12 at 3:45 PM, revealed the RN Supervisor (on duty at the time of Resident #1's death) did call her for direction about calling 911, but the RN Supervisor did not ask her whether or not a Code should be called, or CPR initiated. She also revealed she did not think to ask if a Code was called or CPR initiated as those things would be a standard of nursing practice and facility policy for a resident who was a Full Code. Interview with the Director of Nursing (DON), on 02/03/12 at 2:20 PM, revealed she was notified by the ED of Resident #1's death at about 7:45 AM on 01/26/12. The DON revealed the RN Supervisor and LPN #5 called her after 7:45 AM. She stated LPN #5 told her she did not call a Code or initiate CPR on Resident #1 because she was so "shocked and she knew Resident #1 was deceased". The DON stated the RN Supervisor told her she relied on the ED to give her direction	F 281		

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F 281	Continued From page 5 regarding CPR and calling 911. The DON revealed an investigation and a plan of correction were initiated immediately upon her arrival at the facility. Interview with Resident #1's attending physician, on 02/02/12 at 3:10 PM, revealed he was not surprised at Resident #1's death due to his/her comorbidity and fragile medical state. However, he stated the nursing staff's failure to call a Code and initiate CPR for Resident #1 was a concern and it would be addressed with the quality assurance committee. Review of the facility documentation submitted to the state agency labeled as plan of correction revealed: - Nursing staff was in-serviced (01/26-29/12) on the facility's policy: Requesting Emergency or Acute Treatment Policy (dated 02/13/09) and the required response when a resident had elected to be a Full Code. - A one hundred (100) percent resident chart audit was completed on 01/26/12 for: 1) verification of Code Status per an advance directive; 2) presence of appropriate signed forms (to include EMS); 3) a Code Status physician's order; and 4) appropriate nursing care plans. - A listing of each units' Full Code residents was placed at each nursing station and a newly created Do Not Resuscitate nursing care plan was placed on the chart of every resident on 01/26/12 who had elected no resuscitation. The state agency surveyor validated the facility's	F 281		

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F 281	Continued From page 6 plan of correction by: - Interviews with RN #2 on 02/02/12 at 2:00 PM, Licensed Practical Nurse (LPN) #1 on 02/02/12 at 3:20 PM, LPN #2 on 02/02/12 at 3:30 PM, LPN Supervisor on 02/03/12 at 9:30 AM, and LPN #6 on 02/03/12 at 9:40 AM revealed all were in-serviced on 01/26/12 on the facility's policy for Emergency or Acute Treatment, the listing of Full Code residents posted at each nursing station, and the newly created care plans for residents who elected to be Do Not Resuscitate (DNR). - Record review for sampled Residents #2 and #3, expanded sample Residents #5 and #6 and unsampled residents A, B, C, and D revealed all had Advance Directives, Emergency Medical Services forms, a care plan, and physician's order signifying their wishes regarding Code Status. Record review for expanded sample Resident #4 revealed the resident had elected to be a Full Code on the Advance Directive, a physician's order for a Full Code, and expanded sample Resident #4's name was on the Full Code listing at his/her nurses' station. - Observations of the facility's 500 Unit nursing station on 02/02/12 at 10:00 AM, the 400 Unit nursing station on 02/02/12 at 10:20 AM, the 300 Unit nursing station on 02/02/12 at 11:00 AM, and the 600 Unit nursing station on 02/02/12 at 11:10 AM, revealed a listing of residents' names on each unit who had elected to be a Full Code on the Advance Directives. -Interview with the Administrator, on 02/03/12 at 3:45 PM, the initial plan of correction had been implemented. Per interview, the Social Workers	F 281		

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F 281	Continued From page 7 would be placed in control of the Advanced Directives and will audit the charts for accuracy. This audit will be monthly for three months then quarterly for the next three quarters to ensure continued compliance.	F 281		