

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

PRINTED: 09/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185446</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/22/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BLUEGRASS CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3576 PIMLICO PARKWAY</b> <b>LEXINGTON, KY 40517</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Survey investigating complaint #KY00022123 was initiated on 08/20/14 and concluded on 08/22/14. Complaint #KY00022123 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 08/22/14 and determined to exist on 08/17/14 with deficiencies cited at 42 CFR 483.20 Resident Assessment, F 279 at a Scope and Severity of "D", and F281 at a Scope and severity of "J"; 42 CFR 483.25 Quality of Care, F309 at a Scope and Severity of "J"; and, 42 CFR 483.75 Administration, F514 at a Scope and Severity of "D". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care, F309. The facility was notified of the Immediate Jeopardy on 08/22/14.</p> <p>On 08/17/14 at approximately 6:15 AM, Licensed Practical Nurse (LPN) #14 found Resident #39 to have a change in condition characterized by decreased responsiveness and lethargy with a rapid pulse and respiratory rate. The LPN requested assistance from Registered Nurse (RN) #2 and the decision was made to arrange for the resident's transport to the hospital for further evaluation and treatment. Resident #38 continued to have a decline in status with an absence of vital signs and cardiopulmonary resuscitation (CPR) was required.</p> <p>Review of the facility's video surveillance camera footage revealed the crash cart was delivered to Resident #39's room at 6:25:13 AM. Continued review of the video footage revealed CPR was concluded and staff exited the resident's room at 6:29:51 AM, approximately four (4) and one-half (1/2) minutes later. RN #2 made the decision to</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 000

Continued From page 1

stop efforts at resuscitation and pronounced Resident #39 to be deceased. Facility policy and the American Heart Association guidelines for performing CPR direct that efforts be continued until the arrival of persons able to provide a higher level of care, e.g. Emergency Medical Services (EMS) or a Physician.

In addition, documentation related to the incident was not complete, and facility staff did not make a 9-1-1 call which would have brought the nearest EMS unit in the area to the facility; instead, staff used a direct line to the facility-contracted EMS, which was a designated line for non-emergency transports. Furthermore, confusion about the calls, including which phone to use, led to the request for EMS being canceled by staff while CPR was ongoing, although the EMS did arrive after resuscitative efforts by facility staff had ceased.

An acceptable Action Plan presented to the State Agency on 08/20/14, which served as the facility's credible Allegation of Compliance, alleged removal of the Immediate Jeopardy on 08/20/14, prior to the initiation of the Abbreviated Survey; therefore, it was determined to be Past Immediate Jeopardy. The State Survey Agency validated both the Immediate Jeopardy and the deficient practice was corrected on 08/20/14 as alleged in the Action Plan.

F 000

F 279  
SS=D

483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

F 279

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F 279

Continued From page 2

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, and review of the facility's policy, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #39) had a Comprehensive Care Plan developed to assess the resident's code status. Resident #39 was admitted with Physician orders for a "Full Code" status. Review of the Care Plan revealed no interventions were initiated to address the resident's status.

The findings include:

Review of the facility's policy titled "Care Planning-Interdisciplinary Team", revised October 2013, revealed the facility's Care Planning/Interdisciplinary Team was responsible to develop an individualized comprehensive care plan for each resident. Continued review

F 279

Past noncompliance: no plan of correction required.

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F 279	<p>Continued From page 3</p> <p>revealed the Comprehensive Care Plan was developed to promote the highest level of functioning the resident could be expected to attain. In addition, the Care Plan was to reflect the resident's expressed wishes regarding care and treatment goals and reflect currently recognized standards of practice for problem areas and conditions.</p> <p>Review of the clinical record revealed the facility admitted Resident #39 on 07/08/14 with diagnoses which included Dementia, Hypertension and Crohn's Disease.</p> <p>Review of the Admitting Physician's orders, dated 07/08/14, revealed Resident #39 had an order for "Full Code". (Full Code status indicates resuscitative measures, including the performance of cardiopulmonary resuscitation (CPR), is to be provided in the event of cardiac and/or respiratory failure.)</p> <p>Review of the Physician's Orders for the month of August, 2014 revealed Resident #39 continued to have "Full Code" orders in place.</p> <p>Review of the Comprehensive Care Plan, dated 07/22/14, revealed no plan or interventions were developed for Resident #39 related to his/her code status.</p> <p>Interview with the Minimum Data Set (MDS) Assessment Nurse, on 08/22/14 at 4:00 PM, revealed Resident #39 should have had a written plan of care related to his/her code status. She stated the Admission Nurse was responsible for specifying each resident's code status on the initial care plan; and, the MDS Nurse should transfer the information to the Comprehensive</p>	F 279		
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F 279 Continued From page 4  
Care Plan after completion of the initial MDS assessment. Review of Resident #39's care plan with the MDS Nurse revealed there were no interventions related to the resident's code status. She did not know why it was missed, stating, "it was an oversight".

Interview with the Director of Nursing, on 08/20/14 at 5:20 PM, revealed during her record review following Resident #39's death, she recognized the absence of a Comprehensive Care Plan related to the resident's code status. She stated although Resident #39 was a "Full Code" and staff was aware and had initiated CPR, there should have been a written plan of care related to the resident's code status.

Continued interview with the DON, on 08/20/14 at 5:20 PM, revealed care plans had been revised on 08/18/14 for all residents related to Full Code status or DNR (Do Not Resuscitate) status. A review of the revised care plans revealed each care plan included written interventions to address the specific code status. The Full Code care plan included interventions to call 9-1-1, initiate CPR and continue CPR until 9-1-1 arrival. Both care plans included an intervention for quarterly review of the resident's code status.

Chart reviews for ten (10) unsampled residents revealed care plans were revised on 08/18/14 to accurately reflect each resident's code status, based on the Physician's orders and Advanced Directives. (Refer to F281 and F309)

F 279

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=J PROFESSIONAL STANDARDS

F 281

The services provided or arranged by the facility

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F 281	<p>Continued From page 5</p> <p>must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and the American Heart Association's (AHA) guidelines for cardiopulmonary resuscitation (CPR), and review of the facility's video surveillance footage, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #39) received CPR according to established professional standards of quality of care.</p> <p>On 08/17/14, Resident #39 was found to be unresponsive by facility staff and CPR was initiated. Through review of the facility's video surveillance footage, it was determined CPR was administered for approximately four (four) and one-half (1/2) minutes. Interviews with staff involved revealed the Registered Nurse (RN) made the decision to stop performing CPR and pronounced the resident dead. Emergency Medical Services (EMS) was called to come to the facility; however, staff ceased resuscitative efforts prior to the arrival of EMS personnel, contrary to facility policy and AHA guidelines.</p> <p>The facility's failure to ensure it's policy and established professional standards were followed was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 08/20/14, and was determined to exist on 08/17/14. The facility was notified of the Immediate Jeopardy on 08/22/14.</p> <p>The facility's written Action Plan, dated 08/18/14, was received on 08/20/14. Based on a validation</p>	F 281	<p>Past noncompliance: no plan of correction required.</p>	
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F 281	<p>Continued From page 6 of the Action Plan, the State Survey Agency determined the deficient practice was corrected related to the provision of CPR in accordance with accepted professional standards on 08/20/14; therefore, it was determined to be Past Immediate Jeopardy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "CPR - Code Blue", dated 12/2010, revealed the facility would administer CPR on all residents unless there was a consent or authorization for "Do Not Resuscitate" (DNR) status and a Physician's Order not to resuscitate. Continued review revealed the following: "CPR will continue until Emergency Medical Assistance arrives to assume responsibility for providing CPR".</p> <p>Interview with the Director of Nursing (DON), on 08/20/14 at 5:20 PM, revealed all licensed nursing staff in the facility were required to be trained in CPR. She stated the training was provided by the AHA.</p> <p>Review of the most current AHA guidelines for CPR performance, dated 2010, revealed rescuers who initiate basic life support (CPR) should continue resuscitative efforts until one of the following occurs: restoration of effective, spontaneous circulation; transfer of care to a team able to provide advanced life support (which includes the administration of intravenous fluids and resuscitative drugs, and the use of electronic devices such as a defibrillator); the rescuer is unable to continue due to exhaustion or danger to self or others; or reliable criteria for irreversible death are present. Continued review of the AHA guidelines revealed accepted signs of irreversible</p>	F 281		
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F 281 Continued From page 7  
death included decapitation, rigor mortis and decomposition of the body.

Review of the clinical record revealed the facility admitted Resident #39 on 07/08/14 with diagnoses which included Dementia, Hypertension, and Crohn's Disease. Review of the Admission Physician's Orders, dated 07/08/14, revealed an order for "Full Code", a status which directs "CPR is to be initiated in the event of cardiac and/or respiratory failure." Continued review of the Physician's Orders for August 2014 revealed Resident #39 continued to have Full Code status.

Review of the SBAR (Situation/Background/Assessment/Request) form (a communication form used by the nursing staff to provide information to the Physician when a resident has a change in condition) revealed Resident #39 was "unresponsive/lethargic" on 08/17/14 at "about" 5:40 AM. Continued review revealed the resident had a heart rate of 125 beats per minute (normal is 60-100) and a respiratory rate of 24 (normal is 12-20). Continued review revealed the resident's blood pressure was "0" and the resident had an oxygen saturation level of 81% (normal is 95-100%) with the use of supplemental oxygen at four (4) liters per minute. Further review of the SBAR revealed a request for transfer to the hospital. Additional review revealed the resident's Physician was notified on 08/17/14 at 6:00 AM of the change in condition, and the form was signed by LPN #14.

Review of the Provisional Report of Death revealed the date and time of death for Resident #39 was 08/17/14 at 6:35 AM.

F 281

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Interview with Licensed Practical Nurse (LPN) #14, on 08/20/14 at 1:30 PM, revealed she was the nurse assigned to care for Resident #39 between 7:00 PM on 08/16/14 and 7:00 AM on 08/17/14. She stated she administered the resident's bedtime medications at approximately 9:45 PM on 08/16/14 and the resident did not exhibit any signs of distress. She further stated she checked on the resident about 3:00 AM on 08/17/14 and the resident appeared to be sleeping with no obvious change in status. Continued interview revealed LPN #14 entered Resident #39's room to administer the morning medications, at approximately 5:45 AM on 08/17/14, and found the resident to be very difficult to arouse, with shallow and rapid respirations and a very weak blood pressure. LPN #14 applied supplemental oxygen and requested assistance from RN #2 in assessing the resident. Further interview revealed RN #2 determined Resident #39 needed to be transferred to the hospital for further evaluation and treatment, and initiated the transfer process by making phone calls, preparing the paperwork and arranging EMS transport.

Review of the facility's video surveillance camera footage for the morning of 08/17/14 revealed LPN #14 entered Resident #39's room at 5:59 AM. At 6:09 AM, LPN #14 was observed to exit the room and enter a discussion with RN #2 at the nursing station. At 6:10 AM, LPN #14 and RN #2 re-entered Resident #39'S room. At 6:11 AM, RN #2 exited the room and went into the medication room behind the nursing station, then was observed to leave the nursing station in a direction away from the resident's room and out of range of the camera. At 6:12 AM, LPN #15 delivered an oxygen concentrator to the doorway

F 281

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F 281	<p>Continued From page 9</p> <p>of the resident's room. RN #2 returned to the resident's room at 6:14 AM, exited at 6:15 AM and proceeded to the nursing station, began pulling papers from a chart and making copies, and made a phone call.</p> <p>Interview with LPN #14, on 08/20/14 at 1:30 PM, revealed after applying oxygen and taking vital signs, Resident #39's condition continued to deteriorate and the resident "went down very fast". LPN #14 stated she called again for assistance from RN #2. She further stated RN #2 called for the crash cart and CPR was initiated. Continued interview revealed RN #2 stopped the CPR at 6:30 AM, before EMS personnel arrived. LPN #14 revealed she had received CPR training and possessed a current CPR card; however, she reported she had not received any training from the facility related to performing CPR or managing a code situation. She stated if she had known on 08/17/14 what she knows now, she would have continued CPR until EMS arrived.</p> <p>Review of the Emergency Code Documentation form revealed Resident #39 was found at 6:16 AM by LPN #14, with a "first set of vital signs" documented as blood pressure "0", respirations "0", and pulse "0". Continued review revealed CPR was started at 6:20 AM. Review of the section titled "Vital Signs After Every 4 Cycles" revealed one set of vital signs was documented at 6:35 AM as blood pressure "0", pulse "0" and respirations "0". Further review revealed the form was signed as completed by RN #2.</p> <p>Continued review of the facility's video surveillance camera footage revealed the following sequence of events. At 6:22 AM on 08/17/14, RN #2 was observed at the nursing</p>	F 281		
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station when LPN #14 came from Resident #39's room and spoke to the RN, at which time both nurses returned to the resident's room. At 6:24 AM, LPN #15 entered and exited the room, and proceeded to deliver the "crash cart" to the doorway of the resident's room at 6:25:13 AM. At 6:29:51 AM and 6:29:59 AM respectively, RN #2 and LPN #14 exited the resident's room, four (4) minutes and thirty-eight (38) seconds after the crash cart had arrived at the room. RN #2 resumed making phone calls and doing paperwork, and had a conversation with RN #6, the day shift nurse who arrived at 6:30 AM. LPN #14 entered the resident's room at 6:31:01 AM and exited at 6:31:12 AM. LPN #14, LPN #15 and RN #6 entered the room at 6:31:30 AM and exited at 6:32:08 AM. LPN #14 entered the room at 6:32:10 AM and exited at 6:34:40 AM. At 6:36 AM, one (1) EMS personnel was observed to ring the bell at the side door of the facility. At 6:38 AM, the EMS personnel was observed speaking to RN #1 at the nursing station, before leaving the area in the direction of the facility's side exit door. The EMS personnel was not observed to enter the room of Resident #39.

Interview with RN #2, on 08/21/14 at 9:05 AM, revealed she could not be sure of the exact time of the incident with Resident #39 on 08/17/14, but knew it was after 5:00 AM. She stated LPN #14 reported Resident #39 was not doing well, and after assessing the resident, RN #2 began making phone calls and other necessary arrangements to transfer the resident to the hospital. Continued interview revealed LPN #14 came back to RN #2 a few minutes later and said "I think (the resident) is dead". RN #2 reported she knew Resident #39 was "Full Code" and went back to the resident's room. Further interview

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revealed Resident #39 was very pale, unresponsive and had no vital signs. RN #2 stated she called for the crash cart and instructed LPN #15 to call 9-1-1. Additional interview revealed while CPR was ongoing, RN #2 could not understand why it was taking so long for the EMS to arrive. She stated she did not know how long CPR was performed, but it was ineffective, i.e. the resident was not responding, and she finally said "forget it". RN #2 reported she had received CPR training and had a current CPR card, but had never been involved in a code situation before and had not received any training from the facility related to performing CPR or managing a code situation. She stated she now knew not to stop CPR until help arrived, but she could not say what she knew at the time of the incident.

Interview with LPN #15, on 08/20/14 at 2:05 PM, revealed she was aware RN #2 had made an initial call on the "Red Phone" for ambulance transport to the hospital for Resident #39. She stated when the resident became unresponsive, RN #2 told her to call the EMS back and tell them to hurry because the resident was "coding". A few moments later, LPN #15 reported, RN #2 said the resident "didn't make it" and instructed her to call the EMS back and cancel the request. Continued interview revealed LPN #15 knew CPR should continue until a Physician or the EMS arrived, but when RN #2 told her to tell the ambulance personnel not to come, she thought the RN knew something she (LPN #15) didn't and she did as she was told.

Review of the EMS report dated 08/21/14, regarding calls to the service related to Resident #39, revealed the initial call from the facility was

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F 281	<p>Continued From page 12</p> <p>received at 6:21 AM, with no resident condition provided. Continued review revealed the second call came at 6:30 AM, with a report of CPR being conducted and an inquiry about how long before the ambulance would arrive. Further review revealed the third call was received at 6:34 AM, when the caller stated "you don't need to come". Review of the EMS "Pre-Hospital Care Report", dated 08/17/14, revealed the initial call was received at 6:21 AM, and the ambulance arrived on the scene at 6:42 AM. Continued review of the EMS narrative note revealed the service was dispatched to the facility for a code. Additionally, the note stated, "calling party called back and canceled run. Arrived on scene and made contact with patient's nurse to confirm that they had discontinued efforts and did not require our presence. No further contact with patient or staff made". Comparison of the EMS times to the times from the facility's video surveillance footage revealed the two clocks were off by four (4) minutes; however, the discrepancy was uniform throughout and intervals between events recorded by both parties were consistent. (Refer to F309)</p> <p>Interview with RN #6, on 08/20/14 at 6:40 PM, revealed she arrived for her shift on 08/17/14 at approximately 6:35 AM. She stated she was informed upon her arrival there had been a death on the North Unit. She stated she saw an Emergency Medical Technician (EMT) from the ambulance service speaking with RN #2. She further stated she assumed, upon seeing the EMT, that EMS had been involved and she was unaware at that time of any problem related to the incident involving Resident #39. Continued interview revealed she was questioned by the DON on 08/18/14 about any knowledge she had</p>	F 281		
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F 281	<p>Continued From page 13 regarding the incident on 08/17/14, and that was the first she knew of any concerns related to the staff's handling of the code situation and their provision of CPR.</p> <p>Interview with the DON, on 08/20/14 at 5:20 PM, revealed she was called at home on the morning of 08/17/14 and informed Resident #39 had "passed". She stated she knew the resident was Full Code status and asked if CPR had been performed and was told it had been. Continued interview revealed when she arrived at the facility on 08/18/14 she began a chart review for Resident #39 and became aware of problems surrounding the incident. Further interview revealed she recognized poor documentation and confusion regarding the calls to EMS, and became aware CPR had been discontinued prior to the arrival of EMS, which was not in accordance with the facility's policy or AHA guidelines. She stated she immediately began an investigation of the events surrounding Resident #39's death, and presented a binder which outlined all actions taken by the facility to correct the identified problems.</p> <p>Interview with Resident #39's Physician, on 08/22/14 at 10:00 AM, revealed facility staff left a message on his phone in the early hours of 08/17/14, between 5:00 AM and 6:00 AM. He stated when he called the facility back, he was informed CPR had been performed but was unsuccessful and the resident had expired. He stated he did not give an order for CPR to be discontinued. Continued interview revealed four (4) minutes was not an appropriate length of time for CPR to have been performed, and he would have expected EMS to arrive and take over. Additionally, the Physician stated there was really</p>	F 281		
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F 281	<p>Continued From page 14</p> <p>no way to know the exact cause of death; it could have been any number of things.</p> <p>Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed his official first day as Administrator of the facility was 08/21/14, after the incident involving Resident #39 occurred. He stated he was made aware of circumstances surrounding the events on 08/17/14 and steps taken by the previous Administrator and the DON to correct the problems identified. He stated he immediately became involved in ensuring education continued to be provided for all nursing staff prior to their return to work, and stated the first Quality Assurance meeting to review data collected related to the facility's Action Plan had taken place earlier on 08/22/14.</p> <p>The facility provided an acceptable Action Plan, which served as the credible Allegation of Compliance (AOC) on 08/20/14, which alleged removal of the Immediate Jeopardy effective 08/20/14. Review of the Action Plan revealed the facility implemented the following corrective actions:</p> <ol style="list-style-type: none"> <li>1. On 08/18/14 and 08/19/14, an audit of 100% of residents' charts was conducted to verify Advanced Directives, orders, and chart identification of code status was complete and accurate. The audits were completed by the DON, Assistant DONs, and the Staff Development Coordinator.</li> <li>2. On 08/18/14 and 08/19/14, an audit of 100% of residents' care plans was conducted to ensure they reflected code status accurately. The audits were completed by the DON, Assistant DONs, and the Staff Development Coordinator.</li> </ol>	F 281		
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F 281	<p>Continued From page 15</p> <p>3. On 08/18/14, an audit of 100% of licensed staff CPR training records conducted to ensure all were current. The audit was completed by the Human Resources Director.</p> <p>4. Beginning 08/18/14, all licensed nurses to receive education related to the initiation of CPR, Advanced Directives, Change in Condition, Physician Notification, SBAR/Assessments/Documentation, and when to notify 9-1-1 vs. non-emergency transportation. Each nurse is required to satisfactorily complete a written post-test on all education. Results of the written post-tests to be reported at the weekly Process Improvement Committee meeting. The DON was responsible for coordinating the education for all licensed nurse and the Staff Development Coordinator was responsible for tracking the attendees and ensuring post-tests were completed successfully by all.</p> <p>5. Beginning 08/18/14 and ongoing, mock code drills to be completed on all shifts by the Staff Development Coordinator and/or Nursing Supervisor. Each drill to be followed by a debriefing with all staff involved. Results of the drills to be reported at the weekly Process Improvement Committee. The Staff Development Coordinator was responsible for coordinating and setting up the Mock Code scenarios, conducted a question and answer session after each Mock Code, and ensure all post-tests were completed successfully.</p> <p>6. Daily chart reviews to be conducted by the DON or her designee to ensure Advanced Directives, code status orders, identification of code status on the chart, and care plans are</p>	F 281		
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F 281	<p>Continued From page 16</p> <p>present. The audit included ensuring each resident's code status was consistent with the Advanced Directives and Physician orders. Results of the chart reviews to be reported at the weekly Process Improvement Committee.</p> <p>The State Survey Agency validated the implementation of the facility's Action Plan as follows:</p> <p>1,2) A review of the CPR Audit forms revealed one hundred and three (103) resident charts were reviewed for the following: each resident's Code Status; the presence of the appropriate paperwork, including a Physician's order, Advanced Directives, and EMS forms when indicated; each chart was correctly labeled to indicate the resident's code status; and the care plan related to code status was current. Review of the Census Board dated 08/19/14, revealed it was a list of each resident in the facility. Continued review revealed the list was utilized to audit 100% of resident charts to ensure each had a "Code Status Sticker" on the inside cover.</p> <p>A chart review for ten (10) unsampled residents revealed all had prominent identification of code status by use of a brightly colored sticker on the inside front cover of the chart, Physician orders were in place, Advanced Directives were in place, and care plans accurately reflected each resident's code status.</p> <p>Interview with the DON, on 08/20/14 at 5:20 PM, revealed care plans had been revised for Full Code status and DNR status. A review of the revised care plans revealed each care plan included written interventions to address the specific code status. The Full Code care plan</p>	F 281		
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F 281	<p>Continued From page 17</p> <p>included interventions to call 9-1-1, initiate CPR and continue CPR until 9-1-1 arrival. Both care plans included an intervention for quarterly review of the code status.</p> <p>3. A review of the CPR Certification Validation form revealed a 100% audit of licensed staff was completed and all but two (2) nurses had a current CPR training card on file with the facility. Review of CPR card photocopies revealed LPN #14, RN #2 and LPN #15 all had current CPR training through the AHA. Interview with the DON, on 08/20/14 at 5:20 PM, and a review of staffing patterns for the facility, revealed at no time was the facility staffed with no CPR-trained individuals in the building.</p> <p>4. A review of educational records revealed mandatory in-service education for all licensed staff was initiated on 08/18/14 and was ongoing. Topics included the following: determination of code status, initiation of CPR using AHA guidelines, calling 9-1-1, continuation of CPR until EMS arrives, and paperwork to be completed upon admission or re-admission related to the resident's code status. In addition, education incorporated the use of the Emergency Protocol, developed by the facility on 08/18/14. Review of the Emergency Protocol revealed training points included resident assessment and change in condition, verification of code status and initiation of CPR if indicated, documentation on the SBAR form, immediate notification of the Physician, calling for routine transport to the hospital via the Red Phone vs calling 9-1-1 via the land line for emergency assistance, and, once initiated, CPR should never be stopped until EMS arrived to relieve facility staff. Further review of the Emergency Protocol revealed "a nurse may only</p>	F 281		
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pronounce the resident deceased if the resident is a verified DNR".

Interviews with SRNA #8 on 08/22/14 at 2:00 PM and 2:20 PM, SRNA #24 on 08/22/14 at 2:05 PM, SRNA #11 on 08/22/14 at 2:10 PM, and SRNA #23 on 08/22/14 at 2:25 PM revealed all had been trained on their role in a Code Blue situation, which included being available to the nurses if needed, calling 9-1-1 if requested, retrieving the resident's chart or other items, ensuring the hallway was clear, and notifying the nurse immediately if a resident appeared to have a change in condition. All of the SRNAs interviewed were able to verbalize the procedure for calling 9-1-1, including which phone was to be used in an emergency.

Interview with LPN #14, on 08/20/14 at 1:30 PM, revealed she remained on suspension from duty and had not been told if or when she could return to work. She stated she had received education on 08/19/14 which covered all aspects related to the appropriate response to a code situation and the performance of CPR. She stated the facility provided a copy of her job description and a training packet which included facility policies and written guidelines related to the training topics. She further acknowledged her misunderstanding related to the two (2) phone lines prior to 08/17/14, but was able to verbally differentiate the Red Phone was for non-emergency transports, and the black phone (land line) was to be used to call 9-1-1 in an emergency, after receiving training.

Telephone interview with RN #9, on 08/21/14 at 10:12 PM, revealed she was working on 08/17/14 when Resident #39 required CPR, but was not

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F 281	<p>Continued From page 19</p> <p>involved in the incident and never entered the resident's room. She stated she had not worked since 08/17/14, but had been notified by the facility that she must complete mandatory in-service training related to codes and CPR before she could work again. Continued interview revealed she was to report to the facility early for her next scheduled shift in order to receive the training prior to assuming duty for resident care.</p> <p>Interview with LPN #15, on 08/22/14 at 2:05 PM, revealed she had been suspended from further duty by the facility pending the completion of the investigation. She stated she had been called in to receive training related to the telephone lines, the proper performance of CPR, and the importance of thorough documentation.</p> <p>Interviews with LPN #16 on 08/22/14 at 3:25 PM, the Minimum Data Set (MDS) Assessment Nurse for the North Unit on 08/22/14 at 3:35 PM, and LPN #1 on 08/22/14 at 3:55 PM, revealed they had received education related to Code Blue and CPR, and all were able to verbalize the process, including to never stop CPR until EMS or a Physician arrived to take over. In addition, the nurses were able to differentiate which phone was to be used in an emergency vs. non-emergency situation.</p> <p>Interview with the Staff Development Coordinator, on 08/21/14 at 5:20 PM, revealed the DON had coordinated all education for nurses. She stated her role in the process was coordination of the mock code drills, and tracking of post-tests and staff attendance at training sessions. She further stated the training was mandatory for all licensed staff on all topics, and attendance was tracked by</p>	F 281		
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F 281	<p>Continued From page 20 check-off against the employee roster.</p> <p>Continued interview revealed all licensed staff was required to complete CPR training, and non-licensed staff was given the opportunity to receive the training on a voluntary basis. Interview with the DON, on 08/20/14 at 5:20 PM, revealed the training was initiated on 08/18/14 and was mandatory for all licensed staff. In addition, non-licensed nursing assistants received training related to their role in the event of a code situation. Continued interview revealed the education would continue until all nursing staff had been in-serviced, and no licensed staff was allowed to work until they had been educated and completed the written post-tests. Review of the post-tests revealed they corroborated the sign-in sheets, covered the topics related to a code situation and the performance of CPR, and all were completed successfully.</p> <p>Review of the training materials utilized for in-service education revealed they included facility policies related to CPR and Code Blue, Advanced Directives, and Acute Condition Changes. In addition, the training packet included examples of the SBAR and Emergency Code Documentation form, a copy of AHA guidelines for performing CPR, and copies of forms used for checking and maintaining the crash cart. Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed he reviewed results of the educational post-tests, and all audit data was reviewed at the weekly QA meeting held on the morning of 08/22/14. He stated the educational packets had been incorporated into new hire orientation, and training would be provided for all new staff as they were hired. He further stated no licensed staff was allowed to</p>	F 281		
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F 281	<p>Continued From page 21</p> <p>work prior to receiving training and attendance was tracked by comparison to the facility's employee roster of nurses.</p> <p>5. Review of the facility's training records revealed Mock Code scenarios were developed and drills were conducted at various locations throughout the building on all shifts. Attendees successfully completed post-tests. Interview with the Staff Development Coordinator, on 08/21/14 at 5:20 PM, revealed she was responsible for coordinating the mock code drills and tracking the written post-test results. She stated five (5) drills had been conducted so far, covering all shifts. Continued interview revealed more drills would be staged in order to catch as many different staff as possible. Review of sign-in sheets for the mock code drills revealed twenty-two (22) different RNs, LPNs and SRNAs had participated in drills on or before 08/20/14.</p> <p>Interview with LPN #1, on 08/22/14 at 3:55 PM, revealed she had participated in a mock code drill and completed a written post-test. She stated the drill was an opportunity to practice the proper response in the case of a code situation. She was able to accurately verbalize the facility's code blue procedure.</p> <p>Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed the Staff Development Coordinator tracked the mock code results and provided them for his review. He stated the collected data had been included for review at the weekly Quality Assurance meeting which occurred earlier on 08/22/14, and all data related to the incident and subsequent training would continue to be reviewed at weekly meetings.</p>	F 281		
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F 281

Continued From page 22

6. Further review of the CPR Audit Forms revealed charts were reviewed daily on 08/20/14 through 08/22/14 for the following: Code Status; verification of appropriate paperwork being in place, including a Physician's order, Advanced Directives, and EMS forms when indicated; the presence of the appropriate label with the resident's code status on each chart; and the presence of a current care plan to accurately reflect the code status. The chart audits represented all new admissions and re-admissions for those dates. Continued review revealed chart reviews were completed for two admissions on 08/20/14. Further review revealed there were no admissions or re-admissions on 08/21/14 or 08/22/14.

Interview with the DON, on 08/22/14 at 5:00 PM, revealed daily chart audits for new admissions and re-admissions would continue to be conducted daily Monday through Friday at the morning Clinical Meetings. She stated meeting attendees included the DON, Assistant DON, Wound Care Nurse, Staff Development Coordinator, the MDS nurses, the Dietary Manager and Medical Records staff. She further stated the daily audits would be ongoing indefinitely, until it was determined by the Quality Assurance Process Improvement (QAPI) team the daily audits were no longer indicated and any identified problems had been corrected. Continued interview revealed data collected from the audits would be reviewed at the weekly QAPI meetings, starting with the meeting held earlier on 08/22/14.

In addition to the above, review of the facility's investigation and documentation related to the incident involving Resident #39 on 08/17/14

F 281

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F 281 Continued From page 23  
revealed LPN #14, LPN #15 and RN #2 were suspended pending the outcome of the investigation, but were called in to participate in the mandatory educational in-services.

F 281

Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed as a result of the facility's investigation, RN #2 was terminated related to her role in stopping CPR without relief from EMS or any other source. He reported LPN #14 and LPN #15 had not returned to work but would be allowed to resume duties once they completed competency check-offs. In addition, both nurses would be placed back into orientation with a preceptor, as if they were newly hired. Continued interview with the Administrator revealed he had been in contact with the facility's contracted EMS provider regarding the staff's confusion related to the two (2) phone lines. He stated the decision had been made to remove the Red Phones, and they were to be taken out on 08/25/14. In the meantime, he stated training had a strong focus on when and how to use the Red Phone vs the regular land line. Additionally, pending the removal of the Red Phones, they were labeled "Call 9-1-1 for emergency".

F 309 483.25 PROVIDE CARE/SERVICES FOR  
SS=J HIGHEST WELL BEING

F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

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F 309

Continued From page 24

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, review of the facility's policy and American Heart Association (AHA) guidelines for cardiopulmonary resuscitation (CPR), and review of the facility's video surveillance footage, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #39) received CPR according to established professional standards to promote the highest practicable physical well-being, in accordance with the comprehensive assessment and Physician's order.

On 08/17/14 at approximately 6:15 AM, Resident #39 was found to be unresponsive by facility staff; CPR was initiated. Through review of the facility's video surveillance footage, it was determined CPR was administered for approximately four and one-half (4 1/2) minutes. Interviews with staff involved revealed the Registered Nurse (RN) made the decision to stop performing CPR and pronounced the resident to be deceased prior to the arrival of Emergency Medical Services (EMS). In addition, staff was confused about the proper procedure for summoning EMS in an emergency situation. Three (3) calls were made by direct line (Red Phone) to the facility's contracted EMS, with the third call being to cancel the request for assistance, while CPR was ongoing. Per facility practice, staff should have called 9-1-1 via the land line for an immediate response by the EMS unit closest to the facility.

Review of Resident #39's Comprehensive Care Plan revealed no interventions were in place regarding the resident's Physician-ordered Full

F 309

Past noncompliance: no plan of correction required.

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F 309	<p>Continued From page 25</p> <p>Code status. (Full Code indicates life-saving measures will be instituted in the event of cardiac or respiratory failure.) Also, review of documentation related to the incident revealed it to be incomplete.</p> <p>The facility's failure to ensure it's policies and AHA guidelines related to CPR were followed, and its failure to ensure staff was knowledgeable regarding the proper method for summoning EMS assistance for routine transport vs an emergency situation, was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 08/20/14, and was determined to exist on 08/17/14. The facility was notified of the Immediate Jeopardy on 08/22/14.</p> <p>The facility's written Action Plan, dated 08/18/14, was received on 08/20/14. Based on a validation of the Action Plan, the State Survey Agency determined the deficient practice was corrected related to the procedure for summoning EMS in an emergency, and related to the provision of CPR in accordance with accepted professional standards; therefore, it was determined to be Past Immediate Jeopardy.</p> <p>The findings include:</p> <p>Review of the policy titled "CPR-Code Blue", dated 12/2010, revealed it was the policy of the facility to administer CPR to any resident unless there was a consent or authorization, and a Physician's order, for Do Not Resuscitate (DNR) status. Continued review revealed the following: "CPR will continue until Emergency Medical Assistance arrives to assume responsibility for providing CPR".</p>	F 309		
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F 309	<p>Continued From page 26</p> <p>Interview with the Director of Nursing (DON), on 08/20/14 at 5:20 PM, revealed all licensed staff in the facility was required to complete AHA CPR training, and expected to follow facility policy and AHA guidelines in the provision of CPR. Subsequent interview with the DON, on 08/21/14 at 3:50 PM, revealed it was her expectation for nurses to thoroughly document all code situations by utilization of the SBAR (Situation/Background/Assessment/Request) form (a communication form used by the nursing staff to provide information to the Physician when a resident has a change in condition) for change in condition, the Emergency Code Documentation form (Code Sheet) and the Nurses' Notes. She further stated her expectation that each resident have a Comprehensive Care Plan which included interventions related to the resident's code status, i.e. a Full Code or DNR care plan. In addition, the DON described the facility's practice for summoning EMS as follows: The "Red Phone" located at each nursing station provided a direct line to the facility's contracted EMS and was to be used for non-emergency situations, e.g. when transport to the hospital was required in the absence of an acute emergency. The facility's regular land line phone was to be used to dial 9-1-1 when emergency assistance was required. She stated the facility did not have a written policy related to the different phone lines.</p> <p>Clinical record review revealed the facility admitted Resident #39 on 07/08/14 with diagnoses which included Dementia, Hypertension, and Crohn's Disease. Review of the admission Physician's Orders, dated 07/08/14, revealed an order for "Full Code". Continued review of the Physician's Orders for August 2014 revealed Resident #39 continued to</p>	F 309		
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F 309	<p>Continued From page 27 have Full Code status.</p> <p>Review of the Comprehensive Care Plan, dated 07/22/14, revealed no interventions were in place to address Resident #39's code status. (See F279)</p> <p>Review of the SBAR form, a communication form used by the nursing staff to provide information to the Physician when a resident has a change in condition, revealed Resident #39 was "unresponsive/lethargic" on 08/17/14 at "about" 5:40 AM. Continued review revealed the resident had a heart rate of 125 beats per minute (normal is 60-100) and a respiratory rate of 24 (normal is 12-20). Continued review revealed the blood pressure was "0" and the resident had an oxygen saturation level of 81% (normal is 95-100%) with the use of supplemental oxygen at four (4) liters per minute. Further review of the "Request" section of the SBAR form revealed a request for transfer to the hospital. Additional review revealed the resident's Physician was notified on 08/17/14 at 6:00 AM of the change in condition, and the form was signed by Licensed Practical Nurse (LPN) #14.</p> <p>Review of the Provisional Report of Death revealed the date and time of death for Resident #39 to be 08/17/14 at 6:35 AM.</p> <p>Review of the Emergency Code Documentation form revealed Resident #39 was found at 6:16 AM by LPN #14, with a "first set of vital signs" documented as blood pressure "0", respirations "0", and pulse "0". Continued review revealed CPR was started at 6:20 AM. Review of the section titled "Vital Signs After Every 4 Cycles" revealed one set of vital signs was documented</p>	F 309		
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F 309	<p>Continued From page 28</p> <p>at 6:35 AM as follows: blood pressure "0"; pulse "0"; and respirations "0". Further review revealed the form was signed as completed by RN #2.</p> <p>Review of the Nurses Notes for 08/17/14 revealed no documentation related to Resident #39's change in condition, the provision of CPR, or the resident's death.</p> <p>Interview with LPN #14, on 08/20/14 at 1:30 PM, revealed she was the nurse assigned to care for Resident #39 between 7:00 PM on 08/16/14 and 7:00 AM on 08/17/14. She stated she administered the resident's bedtime medications at approximately 9:45 PM on 08/16/14 and the resident did not exhibit any signs of distress. She further stated she checked on the resident about 3:00 AM on 08/17/14 and the resident appeared to be sleeping with no obvious change in status. Continued interview revealed LPN #14 entered Resident #39's room to administer the morning medications, at approximately 5:45 AM on 08/17/14, and found the resident to be very difficult to arouse, with shallow and rapid respirations and a very weak blood pressure. LPN #14 stated she applied supplemental oxygen and requested assistance in assessing the resident from RN #2. Further interview revealed RN #2 determined Resident #39 needed to be transferred to the hospital for further evaluation and treatment, and initiated the transfer process and arranging for EMS transport.</p> <p>Review of the facility's video surveillance camera footage for the morning of 08/17/14 revealed LPN #14 entered Resident #39's room at 5:59 AM, nineteen (19) minutes after the time documented on the SBAR form. At 6:09 AM, LPN #14 was observed to exit the room and enter a discussion</p>	F 309		
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F 309	<p>Continued From page 29</p> <p>with RN #2 at the nursing station. At 6:10 AM, LPN #14 and RN #2 re-entered the room of Resident #39. At 6:11 AM, RN #2 exited the room and went into the medication room behind the nursing station, then was observed to leave the nursing station in a direction away from the resident's room and out of range of the camera. At 6:12 AM, LPN #15 delivered an oxygen concentrator to the doorway of the resident's room. RN #2 returned to the resident's room at 6:14 AM, exited at 6:15 AM and proceeded to the nursing station, began pulling papers from a chart and making copies, and made a call using the facility's land line (black) phone.</p> <p>Further interview with LPN #14, on 08/20/14 at 1:30 PM, revealed after applying oxygen and taking vital signs, Resident #39's condition continued to deteriorate and the resident "went down very fast". LPN #14 stated she called again for assistance from RN #2. She further stated RN #2 called for the crash cart and CPR was initiated. Continued interview revealed RN #2 stopped the CPR at 6:30 AM, before EMS personnel arrived. She stated after CPR was stopped, she began providing post-mortem care for Resident #38, which included cleaning the resident and preparing the body to be picked up by the funeral home.</p> <p>Interview with LPN #14 revealed she had received CPR training and possessed a current CPR card; however, she reported she had not received any training from the facility related to performing CPR or managing a code situation. Further interview revealed she had never been involved in a code situation before 08/17/14 and any error she made was due to a lack of knowledge. She stated if she had known on</p>	F 309		
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F 309	<p>Continued From page 30</p> <p>08/17/14 what she knows now, she would have continued CPR until EMS arrived.</p> <p>Continued review of the facility's video surveillance camera footage revealed the following sequence of events. At 6:22 AM on 08/17/14, RN #2 was observed to be at the nursing station when LPN #14 came from Resident #39's room and spoke to the RN, at which time both nurses returned to the resident's room. LPN #15 delivered the "crash cart" to the doorway of the resident's room at 6:25:13 AM. At 6:29:51 AM and 6:29:59 AM respectively, RN #2 and LPN #14 exited the resident's room, four (4) minutes thirty-eight (38) seconds after the crash cart had arrived at the room. RN #2 resumed making phone calls and doing paperwork, and had a conversation with RN #6, the day shift nurse who arrived at 6:30 AM. LPN #14 entered the resident's room at 6:31:01 AM and exited at 6:31:12 AM. LPN #14, LPN #15 and RN #6 entered the room at 6:31:30 AM and exited at 6:32:08 AM. LPN #14 entered the room at 6:32:10 AM and exited at 6:34:40 AM. At 6:36 AM, one (1) EMS personnel was observed to ring the bell at the side door of the facility. At 6:38 AM, the EMS personnel was observed speaking to RN #2 at the nursing station, before leaving the area in the direction of the facility side exit door. The EMS personnel was not observed to enter the room of Resident #39.</p> <p>Review of the EMS report dated 08/21/14, regarding calls to the service related to Resident #39, revealed the initial call from the facility was received at 6:21 AM, with no resident condition provided. (Per video footage, this call was made by RN #2.) Continued review revealed the second call came at 6:30 AM, with a report of</p>	F 309		
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CPR being conducted and an inquiry about how long before the ambulance would arrive. Further review revealed the third call was received at 6:34 AM, when the caller stated "you don't need to come". (Video footage revealed the second and third calls were made by LPN #15.)

Review of the EMS "Pre-Hospital Care Report", dated 08/17/14, revealed the initial call was received at 6:21 AM, and the ambulance arrived on the scene at 6:42 AM. Continued review of the EMS narrative note revealed the service was dispatched to the facility for a code. Additionally, the note stated, "calling party called back and canceled run. Arrived on scene and made contact with patient's nurse to confirm that they had discontinued efforts and did not require our presence. No further contact with patient or staff made". Comparison of the EMS times to the times from the facility's video surveillance footage revealed the two clocks were off by four (4) minutes, i.e. the Red Phone times were four (4) minutes ahead of the video surveillance times. However, the discrepancy was uniform throughout and the intervals between events recorded by both parties were consistent.

Interview with RN #2, on 08/21/14 at 9:05 AM, revealed she could not be sure of the exact time of the incident with Resident #39 on 08/17/14, but knew it was after 5:00 AM. She stated LPN #14 reported Resident #39 was not doing well, and after assessing the resident to be lethargic, pale and breathing rapidly and shallowly, RN #2 began making phone calls and other necessary arrangements to transfer the resident to the hospital. She stated the arrangements included a request, via the Red Phone, for non-emergency transport to the hospital. Continued interview

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revealed LPN #14 came back to RN #2 a few minutes later and said "I think (the resident) is dead". RN #2 reported she knew Resident #39 was "Full Code" and went back to the resident's room to initiate CPR if necessary. Further interview revealed Resident #39 was very pale, unresponsive and had no vital signs. RN #2 stated she called for the crash cart and instructed LPN #15 to call 9-1-1. She explained she meant for LPN #15 to use the land line phone to dial 9-1-1, but the LPN used the Red Phone instead, which only accessed one EMS when another may have been closer. She further explained, believing LPN #15 called 9-1-1, RN #2 instructed LPN #15 to cancel the call RN #2 made earlier, via the Red Phone, to request a routine transport to the hospital for Resident #39. Additional interview revealed she and LPN #14 performed CPR. She reported while CPR was ongoing, she could not understand why it was taking so long for the EMS to arrive. She stated she did not know how long CPR was performed, but it was "not very long". RN #2 stated CPR was ineffective, i.e. the resident was not responding, and she finally said "forget it". She stated she and LPN #14 checked for a pulse periodically during CPR, but she did not know how many times. RN #2 reported she had received CPR training and had a current CPR card, but had never been involved in a code situation before and had not received any training from the facility related to performing CPR or managing a code situation. She stated she now knew not to stop CPR until help arrived, but could not say what she knew at the time of the incident.

Interview with LPN #15, on 08/20/14 at 2:05 PM, revealed she was aware RN #2 had made an initial call on the "Red Phone" for ambulance

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F 309	<p>Continued From page 33</p> <p>transport to the hospital for Resident #39. She stated when the resident became unresponsive, RN #2 told her to call the EMS back and tell them to hurry because the resident was "coding". A few moments later, LPN #15 reported, RN #2 said the resident "didn't make it" and instructed her to call the EMS back and cancel the request. Continued interview revealed LPN #15 knew CPR should continue until a Physician or the EMS arrived, but when RN #2 told her to tell the ambulance personnel not to come, she thought the RN knew something she (LPN #15) didn't and she did as she was told.</p> <p>Interview with RN #6, on 08/20/14 at 6:40 PM, revealed she arrived for her shift on 08/17/14 at approximately 6:35 AM. She stated she was informed upon her arrival there had been a death on the North unit. She stated she saw an Emergency Medical Technician (EMT) from the ambulance service speaking with RN #2. She further stated she assumed, upon seeing the EMT, that EMS had been involved and she was unaware at that time of any problem related to the incident involving Resident #39. Continued interview revealed she was questioned by the DON on 08/18/14 about any knowledge she had regarding the incident on 08/17/14, which was the first she was aware of any concerns related to the staff's handling of the code situation and their provision of CPR for Resident #39. Further interview revealed staff was to use the land line and dial 9-1-1 when there was an emergency need for assistance. She stated the Red Phone was a direct line to one (1) EMS and was for routine transports. She further stated dialing 9-1-1 reached a dispatcher with access to more than one service for a faster response time.</p>	F 309			

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Interview with the DON, on 08/20/14 at 5:20 PM, revealed she was called at home on the morning of 08/17/14 and informed Resident #39 had "passed". She stated she knew the resident was Full Code status and asked if CPR had been performed and was told it had been. Continued interview revealed when she arrived at the facility on 08/18/14 she began a chart review for Resident #39 and became aware of problems surrounding the incident. Further interview revealed she recognized poor documentation and confusion regarding the calls to EMS, and became aware CPR had been discontinued prior to the arrival of EMS, which was not in accordance with facility policy or AHA guidelines. She stated she immediately suspended the three (3) nurses involved, LPNs #14 and #15, and RN #2. She began an investigation of the events surrounding Resident #39's death, and presented a binder which outlined all actions taken by the facility to correct the identified problems.

Interview with Resident #39's Physician, on 08/22/14 at 10:00 AM, revealed facility staff left a message on his phone in the early hours of 08/17/14, between 5:00 AM and 6:00 AM. He stated he saw there was a message from the facility but did not listen to the message, just called the facility. He reported when he reached the facility, he was informed CPR had been performed but was unsuccessful and Resident #39 had expired. He stated he did not give an order for CPR to be discontinued. Continued interview revealed he did not believe four (4) minutes was not an appropriate length of time for CPR to have been performed, and he would have expected EMS to arrive and take over. Additionally, the Physician stated there was really no way to know the exact cause of death; it could

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have been any number of things.

Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed his official first day as Administrator of the facility was 08/21/14, after the incident involving Resident #39 occurred. He stated he was made aware of circumstances surrounding the events on 08/17/14 and steps taken by the previous Administrator and the DON to correct the problems identified. Continued interview revealed he reviewed the video surveillance camera footage more than once. He stated it was clear CPR was discontinued prior to arrival of EMS, and when it was determined efforts only lasted four (4) and a half minutes, the decision was made to terminate RN #2 for her poor judgment in discontinuing rescue efforts. He further stated a realization of staff's use of the Red Phone three (3) times was recognized as an inappropriate attempt to procure emergency medical assistance. Furthermore, by comparing the times the Red Phone was used with the EMS report and staff interviews, it was clear the land line (black phone) was not used to dial 9-1-1 but was used for contacting the resident's Physician and family. Additionally, he reported he immediately became involved in ensuring education continued to be provided for all nursing staff prior to their return to work, and stated the first Quality Assurance meeting to review data collected related to the facility's Action Plan had taken place earlier on 08/22/14.

The facility provided an acceptable Action Plan, which served as the credible Allegation of Compliance (AOC) on 08/20/14, which alleged removal of the Immediate Jeopardy effective 08/20/14. Review of the Action Plan revealed the facility implemented the following corrective

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F 309	Continued From page 36 actions:  1. On 08/18/14 and 08/19/14, an audit of 100% of residents' charts was conducted to verify Advanced Directives, orders, and chart identification of code status was complete and accurate. The audits were completed by the DON, Assistant DONs, and the Staff Development Coordinator.  2. On 08/18/14 and 08/19/14, an audit of 100% of residents' care plans was conducted to ensure they reflected code status accurately. The audits were completed by the DON, Assistant DONs, and the Staff Development Coordinator.  3. On 08/18/14, an audit of 100% of licensed staff CPR training records conducted to ensure all were current. The audit was completed by the Human Resources Director.  4. Beginning 08/18/14, all licensed nurses to receive education related to the initiation of CPR, Advanced Directives, Change in Condition, Physician Notification, SBAR/Assessments/Documentation, and when to notify 9-1-1 vs. non-emergency transportation. Each nurse is required to satisfactorily complete a written post-test on all education. Results of the written post-tests to be reported at the weekly Process Improvement Committee meeting. The DON was responsible for coordinating the education for all licensed nurse and the Staff Development Coordinator was responsible for tracking the attendees and ensuring post-tests were completed successfully by all.  5. Beginning 08/18/14 and ongoing, mock code drills to be completed on all shifts by the Staff	F 309		
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Development Coordinator and/or Nursing Supervisor. Each drill to be followed by a debriefing with all staff involved. Results of the drills to be reported at the weekly Process Improvement Committee. The Staff Development Coordinator was responsible for coordinating and setting up the Mock Code scenarios, conducted a question and answer session after each Mock Code, and ensure all post-tests were completed successfully.

6. Daily chart reviews to be conducted by the DON or her designee to ensure Advanced Directives, code status orders, identification of code status on the chart, and care plans are present. The audit included ensuring each resident's code status was consistent with the Advanced Directives and Physician orders. Results of the chart reviews to be reported at the weekly Process Improvement Committee.

The State Survey Agency validated the implementation of the facility's Action Plan as follows:

1,2) A review of the CPR Audit forms revealed one hundred and three (103) resident charts were reviewed for the following: each resident's Code Status; the presence of the appropriate paperwork, including a Physician's order, Advanced Directives, and EMS forms when indicated; each chart was correctly labeled to indicate the resident's code status; and the care plan related to code status was current. Review of the Census Board dated 08/19/14, revealed it was a list of each resident in the facility. Continued review revealed the list was utilized to audit 100% of resident charts to ensure each had a "Code Status Sticker" on the inside cover.

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F 309	<p>Continued From page 38</p> <p>A chart review for ten (10) unsampled residents revealed all had prominent identification of code status by use of a brightly colored sticker on the inside front cover of the chart, Physician orders were in place, Advanced Directives were in place, and care plans accurately reflected each resident's code status.</p> <p>Interview with the DON, on 08/20/14 at 5:20 PM, revealed care plans had been revised for Full Code status and DNR status. A review of the revised care plans revealed each care plan included written interventions to address the specific code status. The Full Code care plan included interventions to call 9-1-1, initiate CPR and continue CPR until 9-1-1 arrival. Both care plans included an intervention for quarterly review of the code status.</p> <p>3. A review of the CPR Certification Validation form revealed a 100% audit of licensed staff was completed and all but two (2) nurses had a current CPR training card on file with the facility. Review of CPR card photocopies revealed LPN #14, RN #2 and LPN #15 all had current CPR training through the AHA. Interview with the DON, on 08/20/14 at 5:20 PM, and a review of staffing patterns for the facility, revealed at no time was the facility staffed with no CPR-trained individuals in the building.</p> <p>4. A review of educational records revealed mandatory in-service education for all licensed staff was initiated on 08/18/14 and was ongoing. Topics included the following: determination of code status, initiation of CPR using AHA guidelines, calling 9-1-1, continuation of CPR until EMS arrives, and paperwork to be completed</p>	F 309		
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F 309	<p>Continued From page 39</p> <p>upon admission or re-admission related to the resident's code status. In addition, education incorporated the use of the Emergency Protocol, developed by the facility on 08/18/14. Review of the Emergency Protocol revealed training points included resident assessment and change in condition, verification of code status and initiation of CPR if indicated, documentation on the SBAR form, immediate notification of the Physician, calling for routine transport to the hospital via the Red Phone vs calling 9-1-1 via the land line for emergency assistance, and, once initiated, CPR should never be stopped until EMS arrived to relieve facility staff. Further review of the Emergency Protocol revealed "a nurse may only pronounce the resident deceased if the resident is a verified DNR".</p> <p>Interviews with SRNA #8 on 08/22/14 at 2:00 PM and 2:20 PM, SRNA #24 on 08/22/14 at 2:05 PM, SRNA #11 on 08/22/14 at 2:10 PM, and SRNA #23 on 08/22/14 at 2:25 PM revealed all had been trained on their role in a Code Blue situation, which included being available to the nurses if needed, calling 9-1-1 if requested, retrieving the resident's chart or other items, ensuring the hallway was clear, and notifying the nurse immediately if a resident appeared to have a change in condition. All of the SRNAs interviewed were able to verbalize the procedure for calling 9-1-1, including which phone was to be used in an emergency.</p> <p>Interview with LPN #14, on 08/20/14 at 1:30 PM, revealed she remained on suspension from duty and had not been told if or when she could return to work. She stated she had received education on 08/19/14 which covered all aspects related to the appropriate response to a code situation and</p>	F 309		
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the performance of CPR. She stated the facility provided a copy of her job description and a training packet which included facility policies and written guidelines related to the training topics. She further acknowledged her misunderstanding related to the two (2) phone lines prior to 08/17/14, but was able to verbally differentiate the Red Phone was for non-emergency transports, and the black phone (land line) was to be used to call 9-1-1 in an emergency, after receiving training.

Telephone interview with RN #9, on 08/21/14 at 10:12 PM, revealed she was working on 08/17/14 when Resident #39 required CPR, but was not involved in the incident and never entered the resident's room. She stated she had not worked since 08/17/14, but had been notified by the facility that she must complete mandatory in-service training related to codes and CPR before she could work again. Continued interview revealed she was to report to the facility early for her next scheduled shift in order to receive the training prior to assuming duty for resident care.

Interview with LPN #15, on 08/22/14 at 2:05 PM, revealed she had been suspended from further duty by the facility pending the completion of the investigation. She stated she had been called in to receive training related to the telephone lines, the proper performance of CPR, and the importance of thorough documentation.

Interviews with LPN #16 on 08/22/14 at 3:25 PM, the Minimum Data Set (MDS) Assessment Nurse for the North Unit on 08/22/14 at 3:35 PM, and LPN #1 on 08/22/14 at 3:55 PM, revealed they had received education related to Code Blue and

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CPR, and all were able to verbalize the process, including to never stop CPR until EMS or a Physician arrived to take over. In addition, the nurses were able to differentiate which phone was to be used in an emergency vs. non-emergency situation.

Interview with the Staff Development Coordinator, on 08/21/14 at 5:20 PM, revealed the DON had coordinated all education for nurses. She stated her role in the process was coordination of the mock code drills, and tracking of post-tests and staff attendance at training sessions. She further stated the training was mandatory for all licensed staff on all topics, and attendance was tracked by check-off against the employee roster.

Continued interview revealed all licensed staff was required to complete CPR training, and non-licensed staff was given the opportunity to receive the training on a voluntary basis. Interview with the DON, on 08/20/14 at 5:20 PM, revealed the training was initiated on 08/18/14 and was mandatory for all licensed staff. In addition, non-licensed nursing assistants received training related to their role in the event of a code situation. Continued interview revealed the education would continue until all nursing staff had been in-serviced, and no licensed staff was allowed to work until they had been educated and completed the written post-tests. Review of the post-tests revealed they corroborated the sign-in sheets, covered the topics related to a code situation and the performance of CPR, and all were completed successfully.

Review of the training materials utilized for in-service education revealed they included facility policies related to CPR and Code Blue,

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Advanced Directives, and Acute Condition Changes. In addition, the training packet included examples of the SBAR and Emergency Code Documentation form, a copy of AHA guidelines for performing CPR, and copies of forms used for checking and maintaining the crash cart. Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed he reviewed results of the educational post-tests, and all audit data was reviewed at the weekly QA meeting held on the morning of 08/22/14. He stated the educational packets had been incorporated into new hire orientation, and training would be provided for all new staff as they were hired. He further stated no licensed staff was allowed to work prior to receiving training and attendance was tracked by comparison to the facility's employee roster of nurses.

5. Review of the facility's training records revealed Mock Code scenarios were developed and drills were conducted at various locations throughout the building on all shifts. Attendees successfully completed post-tests. Interview with the Staff Development Coordinator, on 08/21/14 at 5:20 PM, revealed she was responsible for coordinating the mock code drills and tracking the written post-test results. She stated five (5) drills had been conducted so far, covering all shifts. Continued interview revealed more drills would be staged in order to catch as many different staff as possible. Review of sign-in sheets for the mock code drills revealed twenty-two (22) different RNs, LPNs and SRNAs had participated in drills on or before 08/20/14.

Interview with LPN #1, on 08/22/14 at 3:55 PM, revealed she had participated in a mock code drill and completed a written post-test. She stated the

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drill was an opportunity to practice the proper response in the case of a code situation. She was able to accurately verbalize the facility's code blue procedure.

Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed the Staff Development Coordinator tracked the mock code results and provided them for his review. He stated the collected data had been included for review at the weekly Quality Assurance meeting which occurred earlier on 08/22/14, and all data related to the incident and subsequent training would continue to be reviewed at weekly meetings.

6. Further review of the CPR Audit Forms revealed charts were reviewed daily on 08/20/14 through 08/22/14 for the following: Code Status; verification of appropriate paperwork being in place, including a Physician's order, Advanced Directives, and EMS forms when indicated; the presence of the appropriate label with the resident's code status on each chart; and the presence of a current care plan to accurately reflect the code status. The chart audits represented all new admissions and re-admissions for those dates. Continued review revealed chart reviews were completed for two admissions on 08/20/14. Further review revealed there were no admissions or re-admissions on 08/21/14 or 08/22/14.

Interview with the DON, on 08/22/14 at 5:00 PM, revealed daily chart audits for new admissions and re-admissions would continue to be conducted daily Monday through Friday at the morning Clinical Meetings. She stated meeting attendees included the DON, Assistant DON, Wound Care Nurse, Staff Development

F 309

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/22/2014
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NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(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
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F 309	<p>Continued From page 44</p> <p>Coordinator, the MDS nurses, the Dietary Manager and Medical Records staff. She further stated the daily audits would be ongoing indefinitely, until it was determined by the Quality Assurance Process Improvement (QAPI) team the daily audits were no longer indicated and any identified problems had been corrected. Continued interview revealed data collected from the audits would be reviewed at the weekly QAPI meetings, starting with the meeting held earlier on 08/22/14.</p> <p>In addition to the above, review of the facility's investigation and documentation related to the incident involving Resident #39 on 08/17/14 revealed LPN #14, LPN #15 and RN #2 were suspended pending the outcome of the investigation, but were called in to participate in the mandatory educational in-services.</p> <p>Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed as a result of the facility's investigation, RN #2 was terminated related to her role in stopping CPR without relief from EMS or any other source. He reported LPN #14 and LPN #15 had not returned to work but would be allowed to resume duties once they completed competency check-offs. In addition, both nurses would be placed back into orientation with a preceptor, as if they were newly hired. Continued interview with the Administrator revealed he had been in contact with the facility's contracted EMS provider regarding the staff's confusion related to the two (2) phone lines. He stated the decision had been made to remove the Red Phones, and they were to be taken out on 08/25/14. In the meantime, he stated training had a strong focus on when and how to use the Red Phone vs the regular land line. Additionally, pending the</p>	F 309		
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NAME OF PROVIDER OR SUPPLIER  <b>BLUEGRASS CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3576 PIMLICO PARKWAY LEXINGTON, KY 40517</b>
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F 309 Continued From page 45  
removal of the Red Phones, they were labeled "Call 9-1-1 for emergency".

F 309

F 514 483.75(l)(1) RES  
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, and review of the facility's policy, it was determined the facility failed to ensure one (1) of three (3) sampled residents' (Resident #39) clinical record completely and accurately reflected the resident's change in condition when Resident #39 had a change in condition, required cardiopulmonary resuscitation (CPR), and became deceased.

The findings include:  
  
Review of the facility's policy titled "Charting and Documentation", revised April 2008, revealed the following: "All services provided to the resident,

Past noncompliance: no plan of correction required.

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NAME OF PROVIDER OR SUPPLIER  <b>BLUEGRASS CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3576 PIMLICO PARKWAY</b> <b>LEXINGTON, KY 40517</b>
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F 514

Continued From page 46

or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record".

Clinical record review revealed the facility admitted Resident #39 on 07/08/14 with diagnoses which included Dementia, Hypertension and Crohn's Disease.

Review of the Provisional Report of Death revealed Resident #39 died on 08/17/14 at 6:35 AM.

Review of the Nurses Notes for 08/17/14 revealed the last entry was made at 12:00 AM when Licensed Practical Nurse (LPN) #14 documented Resident #39 was "resting quietly with eyes closed", and had "no signs and symptoms of pain or distress". Continued review of the Nurses Notes revealed no documentation related to a change in condition, or the resident's death approximately six (6) and one-half (1/2) hours later.

Interview with LPN #14, on 08/20/14 at 1:30 PM, revealed she should have documented events related to the resident's change in condition, the provision of CPR and the resident's death in the Nurses Notes. She stated everything happened so fast and it was the end of the shift. She further stated she just forgot to document in the Nurses Notes.

Interview with the Director of Nursing (DON), on 08/21/14 at 3:50 PM, revealed it was her expectation for all documentation, including the Nurses Notes, to be completed timely and accurately. She stated her clinical record review following the death of Resident #39 revealed staff

F 514

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185446</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/22/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BLUEGRASS CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3576 PIMLICO PARKWAY LEXINGTON, KY 40517</b>
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(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
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F 514	<p>Continued From page 47</p> <p>had failed to document the events fully. She further stated she had incorporated the facility's expectation related to documentation requirements into the mandatory education, which was initiated by the DON on 08/18/14 and was ongoing until all licensed staff completed the training.</p> <p>Review of the training materials utilized for in-service education revealed the training packet included examples of the SBAR and Emergency Code Documentation form, facility requirements for documentation in the clinical record, including the Nurses Notes, and copies of forms used for checking and maintaining the crash cart.</p> <p>Interview with the Administrator, on 08/22/14 at 3:35 PM, revealed he reviewed results of the educational post-tests, and all audit data was reviewed at the weekly QA meeting held on the morning of 08/22/14. He stated the educational packets had been incorporated into new hire orientation, and training would be provided for all new staff as they were hired. He further stated no licensed staff was allowed to work prior to receiving training and attendance was tracked by comparison to the facility's employee roster of nurses. (Refer to F281 and F309)</p>	F 514		
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