Corrective Action for the Resident
Found with Deficient Practice:
1. For Resident #3, the resident was discharged from the facility on 09/05/11.

Corrective Action for Having Potential for Same Deficient Practice:
1. All residents have been identified as having potential to be affected by this practice.
2. The Directors of Medical Records, Social Services, and Nursing Administration have been inserviced on 10/07/11 by the Executive Director and the Director of Nursing on identifying and documenting residents' code status.

Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Recur:
1. Director of Nursing and Executive Director has conducted a 100% audit on 10/06/11-10/07/11 to assure proper documentation of code status. All new admissions and readmissions will have a daily audit by Executive Director and/or Designee to assure proper documentation of code status occurs.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the facility 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 discloseable 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 discloseable 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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Review of the entire medical record of Resident #3 revealed corresponding physician orders were not written or obtained documenting the preference to "attempt resuscitation" in the event of cardiac failure.

In an interview on 10/6/11 at 1:50 PM Nurse #1 stated the facility system to determine DNR (do not resuscitate) status was an orange dot on the outside spine of each resident's medical record. If a resident's preference was to be resuscitated, Nurse #1 stated there would not be a dot on the outside spine of the individual residents medical record. In addition, Nurse #1 stated the Individual residents Medication Administration Record (MAR) would indicate the code status of the resident. In an interview on 10/6/11 at 2:15 PM Nurse #2 stated the facility system to determine DNR status was an orange dot on the outside spine of each resident's medical record. If a resident's preference was to be resuscitated, Nurse #2 stated there would not be a dot on the outside spine of the individual resident's medical record. In addition, Nurse #2 stated the Individual residents MAR would indicate the code status of the resident.

Review of nurses notes in the medical record of Resident #3 revealed on 9/6/11 at approximately 5:25 AM Resident #3 was found unresponsive with no blood pressure, heart beat, respirations and her body was cool to touch. On 10/6/11 at 2:35 PM a telephone interview was conducted with the nurse (Nurse #3) that found Resident #3 unresponsive on 9/6/11 at 5:25 AM. Nurse #3 recalled that Resident #3 was found unresponsive with no blood pressure, heart beat or respirations. Nurse #3 stated that Resident #3

### Monitoring:

1. A random audit will be done monthly for four months by Executive Director and/or Designee of no less than 50% of all current residents to assure proper documentation of code status.

2. The results will be reported monthly to QA Committee and the Medical Director. The QA Committee meets next on Wednesday, November 16, 2011 when the above issues will be discussed by the committee and the Medical Director. Recommendations and changes will be implemented as indicated by members of the Interdisciplinary/QA team members.
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was cool to touch and "pretty stiff". Nurse #3 stated that she recalled Resident #3 was DNR based on what was indicated on the resident's medical record.

Review of the closed medical record of Resident #3 revealed a sheet in the inside front of the chart which had bright colored stickers indicating "allergies", "alert charting" and "full code". The stickers that would have been removed from the outside spine of the resident's medical record had been placed on this same sheet. There were two stickers listing the resident's name, room number and physician as well as an orange dot (representing DNR status).

On 10/6/11 at 2:50 PM the facility Director of Nursing (DON) and administrator stated the orange dot should not have been placed on the outside spine of the medical record of Resident #3 as the stated preference was for resuscitation (full code status). The DON reviewed the medical record of Resident #3 and stated it was her expectation for the code status to be reflected in a physician's order so that it would be included on the printed monthly physician orders and MAR (in a blocked section labeled "code status"). The DON stated nursing staff would determine a resident's code status through review of the individual resident's MAR, monthly physician orders, MOST form or identifying if an orange dot was on the outside spine of the medical record. The DON stated the Medical Records Director was responsible for setting up a resident's medical record on admission and placing an orange dot on the outside spine if indicated.

On 10/6/11 at 2:55 PM Nurse #4 stated she was
<table>
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<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 514</td>
<td>Continued From page 3 covering for the Medical Records Director at the time Resident #3 was admitted to the facility. Nurse #4 stated she was aware to use the MOST form to determine if an orange dot (indicating DNR status) should be placed on the outside spine of the individual medical record. Nurse #4 stated she did not recall placing an orange dot on the outside spine of the medical record of Resident #3 and could not explain how it would have been placed on the resident's medical record.</td>
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