STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

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F 000	INITIAL COMMENTS An unannounced abbreviated Medicare/Medicaid survey was conducted on 06/22/2022 through 06/23/2022. Three complaints (VA00055257 - Substantiated with deficiency, VA00055134 - Unsubstantiated, VA00053578 - Substantiated without deficiency) were investigated during the survey. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 93 at the time of the survey. The survey sample consisted of 8 current resident reviews and 6 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to follow physician's orders for 1 of 14 residents in the survey sample, Resident #12. For Resident #12, the facility staff failed to follow the physician's order for the resident's code status of do not resuscitate (DNR).	F 684	F 684 Resident # 12 is no longer in the facility. Current residents in the center have the potential to be affected. Licensed nurses were educated by the SDC/ Designee on following MD orders for Code status and where to find code status in the medical record.	7/19/22

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

Electronically Signed | 07/20/2022

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F 684	Continued From page 1 This was a closed record review. The findings included: Resident #12's diagnosis list indicated diagnoses, which included, but not limited to Congestive Heart Failure, Type 2 Diabetes Mellitus, Nonalcoholic Steatohepatitis, Portal Hypertension, and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. The admission minimum data set (MDS) with an assessment reference date (ARD) of 5/08/22 assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 indicating Resident #12 was severely cognitively impaired. Resident #12's physician's orders included an order dated 5/01/22 5:49 pm stating "Code Status DNR". This order was created and confirmed in the resident's electronic medical record by registered nurse (RN) #3 and electronically signed by the attending physician on 5/04/22 at 7:42 pm. Resident #12's clinical record also included a completed Virginia Department of Health Durable Do Not Resuscitate Order form dated 5/01/22 and signed by the resident, the resident's spouse, and a physician. A "change of condition" progress note by RN #3 dated 5/15/22 at 1:48 pm read "At 1315 (1:15 pm), pt (patient) was sitting up in wheelchair with head slumped forward. CNA (certified nursing assistant) attempted to rouse pt with no success. Undersigned entered room, attempted sternal rub	F 684	The DON/ Designee will monitor new orders report for code status and DDNR paperwork 5x weekly in clinical meeting. Results of the monitoring will be presented to the QAPI Committee for review and discussion, once the committee determined the problem no longer exist Then monitoring will be conducted on a random basis. Date of Compliance 7/19/22	

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with no success. Code Blue was called at that time. Pupils unresponsive to light. BG (blood glucose) 107 92% on O2 (oxygen) via rebreather at 12 l/m (liters per minute). BP (blood pressure) 68/53, HR (heart rate) 99 and a thready pulse. 1322 (1:22 pm): 22 G (gauge) IV started in R (right) hand, NS (normal saline) started on gravity flow. 1324 (1:24 pm): 82/58, 100% O2 72 pulse, 10 RR (respiratory rate). 1326 (1:26 pm): EMT arrived and continued care. IO (intraosseous infusion) started in right shin with NS via EMT. (Spouse) (name omitted) and (adult child) (name omitted) made aware".

A physician's note dated 5/16/22 at 12:22 pm read in part "Patient had been progressing well but was found unresponsive on the 15th by nursing staff. Patient was subsequently transferred to (name omitted) ER where (he/she) was admitted to the ICU for a cardiovascular arrest and questionable stroke".

On 6/23/22 at 10:57 am, surveyor spoke with RN #3 regarding Resident #12. RN #3 stated they found Resident #12 in wheelchair with head slumped over with a weak thready pulse, they did a sternal rub and told the CNA to call a Code Blue and a CNA called 911. RN #3 stated licensed practice nurse (LPN) #2, LPN #4, and RN #4 responded and assisted the resident to the ground and a CNA brought in the crash cart. RN #3 stated LPN #4 was pulling supplies from the crash cart, RN #4 started an IV, a non-rebreather oxygen mask at 12 l/m was applied and LPN #2 did a short round of chest compressions. RN #3 stated they then got a weak thready pulse. EMTs arrived in 10 to 15 minutes and took over care, non-rebreather mask was switched to an ambu bag and RN #3 provided the ventilation until the

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resident entered the ambulance. RN #3 stated EMTs never did chest compressions or shock the resident. When asked why the code was started, RN #3 responded "I did not check (his/her) code status". RN #3 further stated at one point they did not have paper work for the resident to be a DNR and the paper work came through a few days before and they were unaware.

On 6/23/22 at 11:38 am, surveyor spoke with LPN #2 who stated they responded to the Code Blue call and Resident #12 was blue, not breathing and they could not find a pulse and did one round of chest compressions and then got a pulse. Surveyor asked why they coded the resident and LPN #2 stated because a Code Blue was called.

On 6/23/22 at 11:53 am, surveyor spoke with the administrator who stated Resident #12's completed DDNR was not given to the facility until 5/11/22 following the facility social worker's request. Administrator stated Resident #12's spouse had taken the DDNR form out of the facility and had the resident's physician sign it.

On 6/23/22 at 10:37 am, surveyor spoke with the director of nursing (DON) regarding Resident #12's code. The DON stated the facility did not discover Resident #12 was a DNR until the resident was at the hospital. The DON stated when Resident #12 was admitted, they were told the resident was a DNR but then the social worker discovered there was no signed DDNR and the resident had to go back to being full code until the spouse brought the DDNR in on 5/11/22. DON stated they immediately began educating staff on the policy and where to locate a resident's code status in point click care (PCC) (electronic medical record system) and a PIP

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(process improvement project) was initiated on 5/18/22. Surveyor received a copy of the PIP dated 5/18/22 for the project entitled "Identification of resident code status and process for initiating CPR, if indicated" with a completion date of 6/30/22.

Facility provided a copy of an "Employee Corrective Action" form dated 5/16/22 which read in part "Describe specific facts including date, time, what happened, witness: CNA called nurse to room of patient (Resident #12) who was found unresponsive and slumped over in WC (wheelchair). Assessment made and CPR started, patient was a DNR and the order was not verified. Patient sent out to hospital..." "Describe the impact the infraction had on the patient, customer, or business: 1) Patient should not have been coded per (his/her) request and MD orders which resulted in transfer to hospital and prolonging (his/her) life. 2) Nurse to always check order prior to starting CPR".

Surveyor was provided a copy of a report sheet page with multiple residents listed including Resident #12. Resident #12's code status was documented as "DNR" on the form. On 6/23/22 at 2:25 pm, the administrator stated the copy was from 5/15/22.

Surveyor requested and received the facility policy entitled "Do Not Resuscitate" which read in part:
Policy: CPR (cardio-pulmonary resuscitation) will not be initiated when there is a valid Do Not Resuscitate (DNR) order located on the patient's permanent medical record.
Procedures:
2. A valid DNR order by the attending physician

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must be in writing, signed and appropriately dated: a valid DNR order may be a fax. A verbal DNR order is not a valid DNR order
4. A Virginia Department of Health Durable Do Not Resuscitate (DDNR) Order form is a valid order

Surveyor also requested and received the facility policy entitled "Cardio-Pulmonary Resuscitation (CPR)" which read in part:
Policy: Cardio-Pulmonary Resuscitation (CPR) will be initiated as a resuscitation procedure to restore breathing and/or heartbeat if any patient is found to be in cardiopulmonary arrest, EXCEPT where the patient's physician has specifically and appropriately documented a DNR order in the patient's permanent medical record.
Procedure:
1. Validate code status.

On 6/23/22 at 6:37 pm, survey team met with the administrator, DON, and regional nurse consultant and discussed the concern of staff failing to follow the physician's order for DNR for Resident #12.

No further information was provided regarding this concern prior to the exit conference on 6/23/22.

This was a complaint deficiency.