STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 07/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

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F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 309	Standard Disclaimer:	8/8/17

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

Electronically Signed | 08/08/2017

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F 309	Continued From page 1 facility failed to immediately initiate cardiopulmonary resuscitation (CPR) for 1 of 1 resident (Resident #1) found unresponsive. The findings included: Resident #1 was admitted to the facility on 7/5/17 with diagnoses which included congestive heart failure (CHF), hypertension, diabetes mellitus (DM), chronic respiratory failure with hypoxia, primary pulmonary hypertension, anemia, chronic kidney disease (stage 3)(ESRD), solitary pulmonary nodule, wheezing, malignant neoplasm of the prostate, chronic obstructive pulmonary disease (COPD) and had a history of other venous thrombosis and embolism with long term use of anticoagulants. Review of facility's Code Status Form dated 7/5/17 and signed by the resident's responsible person, read in part, "Full Code," "I named resident, hereby declare my decision to be regarded as Full Code Status and wish to have all opportunities available to me to extend my life and to make me comfortable." A review of the medical orders 7/5/17 revealed that Resident #1 had requested CPR if he had no pulse and was not breathing. A review of the interim care plan dated 7/5/17 revealed that Resident #1 was care planned as a full code with no living will or treatment limitation. The most recent Minimum Data Set dated 7/10/17 revealed Resident #1 was cognitively intact. A review of the Nurses' Note (late entry) dated	F 309	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. Resident #1 is no longer in the facility. The code status of other residents that have the potential to be affected has been reviewed and posted inside their closet door. Nurse #1 was in-serviced on the facility Unresponsive Resident Procedure on 7/28/2017 by the Administrator. 100% of staff were in-serviced by the Administrator, Director of Nursing, Assistant Director of Nursing or Nursing Supervisors on the Unresponsive Resident Procedure staring on 07/26/2017. All new hires will be in-serviced on the facility Unresponsive Resident Procedure by the ADON/SDC. Nurse #1 also verbalized the Unresponsive Resident Procedure to the Administrator on 07/28/2017. 100% of all staff have verbalized the Unresponsive Resident Procedure to the Administrator, Director of Nursing, Assistant Director of Nursing or Nursing Supervisors utilizing a Unresponsive Resident QI tool staring on 07/26/2017. All new hires will be required to verbalize the Unresponsive Resident Procedure. The Administrator, Director of Nursing,	

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F 309	Continued From page 2 7/11/17 at 12:46 AM revealed that Staff Nurse #1 found Resident #1 unresponsive and cardiopulmonary resuscitation (CPR) was started and 911 called at that time. Emergency Medical Services (EMS) arrived at the facility and pronounced Resident #1 dead on 7/10/17 at 9:42 PM. On 7/24/17 at 3:51 PM Nurse #1 stated she found Resident #1 on 7/10/17 unresponsive and was not sure of the exact time, but immediately walked from the resident's room, which was the second room from the nurse's station and told Staff Nurse #2 that Resident #1 was not breathing. Nurse #2 informed nurse # 1 that Resident#1 was a full code, Nurse #1 stated she immediately called 911 and called the overhead code and her and Staff Nurse#2 returned to the resident room and Staff Nurse #2 started CPR. Nurse #1 further stated that other nurses ran to the resident room to help with the crash cart. Staff Nurse #1 revealed she did not start CPR immediately because she did not know the resident's code status. She revealed she did not yell out because the resident's family member was across the hall and she did not want to upset the resident and the family member. Staff Nurse #1 revealed she left the resident alone to find out the resident code status to call 911 and to get help to start CPR. On 7/24/17 at 5:31 PM Nurse #2 stated that Staff Nurse #1 came out of Resident #1's room and said he was unresponsive and asked if he was a full code. Nurse #2 stated she looked in Resident #1's medical record and he was a full code, Nurse #1 called 911 and called overhead for staff to help with CPR. Nurse #2 stated she started CPR, with the help of a nursing assistant and the	F 309	Assistant Director of Nursing or Nursing Supervisors will conduct random QI audits of staff requiring them to verbalize the Unresponsive Resident Procedure 1 x per shift per week for 4 weeks, then one audit per shift per month x 2 months. Mock drills will be conducted1 x per shift per week for 4 weeks, then one audit per shift per month x 2 months. Results of the audits will be reviewed by the Director of Nursing Weekly x 4 weeks, then monthly x 2 months. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x 3 months.	

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F 309	Continued From page 3	F 309		

supervisor, both the nursing assistant and the supervisor no longer works at the facility and phone numbers had been changed and they could not be reached. Resident #1 had no pulse and he was not breathing, we put the back board under him and started compressions. Nurse #2 stated she did not record the time when CPR was started but continued to perform CPR until EMS arrived.

On 7/25/17 at 8:30 AM Resident #1's physician stated that with Resident#1's multiple medical history it would be difficult to determine whether or not the outcome would have been different. The physician further stated that the resident could have thrown a blood clot due to his history of embolism. He had just been released from the hospital for acute CHF and retaining fluid, and also had cancer of the prostate. The physician stated her expectation of a nurse would be to assess the resident, and if they were a full code, call for help, stay with the patient and start CPR.

On 7/25/17 at 10:25AM, the Director of Nursing (DON) stated she did not know of any problems related to the code of Resident #1. The DON stated Resident#1's code status was in his chart and was on the MAR, which was in the computer. The DON further stated the nurse would have to check for his code status to begin CPR.

On 7/24/17 at 3:47 PM the Administrator stated it was her expectation for the staff to stay with the resident and start CPR if they were a full code.

On 7/24/17 at 3:49PM the Director of Nursing (DON) stated it was her expectation for the staff to call for help and not leave the resident and start CPR if they were a full code.

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