

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

PRINTED: 04/13/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>525390</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROCK HAVEN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3400 N CTY TRK HWY F PO BOX 920 JANESVILLE, WI 53547</b>		
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F 000	INITIAL COMMENTS  Surveyor: 27973  During this complaint and self report investigation at Rock Haven conducted on 4/7/15,  # of federal citations issued: 1  The most serious citation is F 155 cited at a severity/scope level of E (potential for harm/pattern).  Census: 117 Sample size: 4 Survey coordinator: 27973	F 000			
F 155 SS=E	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES  The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.  The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 155	Continued From page 1  This REQUIREMENT is not met as evidenced by: Surveyor: 27973  Based on interview and record review, the facility did not ensure that each resident has the right to refuse treatment and to formulate an advance directive for 1 of 4 residents (Resident 1) reviewed. This failure has the potential to affect all 77 residents, from a census of 117, who reside at the facility and wish for no resuscitation efforts by the facility in the event of respiratory or cardiac arrest.  The facility's policy for "Code Blue" indicated that resuscitation efforts would not be carried out if the resident or decision-maker did not formulate an advance directive related to CPR or the refusal of CPR. Resident 1 had advance directive for no resuscitation in the event of cardiac or respiratory arrest. Resident 1 was found on his bedroom floor and was noted to be non-responsive on 3/30/15. The facility staff initiated CPR, despite Resident 1's wishes for no CPR. This is evidenced by: The facility's policy titled "Code Blue-Cardiopulmonary resuscitation" (undated) states in part, "in the event a resident experiences a cardiac or respiratory arrest, cardiopulmonary resuscitation measures will be implemented if the resident or resident's guardian has requested CPR in writing. In the event a resident experiences a cardiac or respiratory arrest, cardiopulmonary resuscitation will not be implemented if: 1. The resident or legal representative has specified in writing 'No CPR.'	F 155			

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F 155	<p>Continued From page 2</p> <p>2. The resident is obviously dead as evidenced by presence of rigormortis and/or dependent lividity.</p> <p>3. The resident/guardian fails to specify CPR instructions. Once CPR is started, it can only be stopped if one the following occurs: 1. Spontaneous return of heartbeat and respirations. 2. Arrival of the paramedics with subsequent transfer to hospital. 3. M.D. on the scene pronounces the resident dead."</p> <p>It is important to note that the facility's policy is not written in accordance of current standards of practice. Current standards are that individuals or their decision-makers, who have signed a DNR order, are the only individuals who will not receive CPR in the event of cardiac or respiratory arrest. Resident 1 has an "Emergency Care Do Not Resuscitate Order (DNR)" signed by Resident 1 on 3/17/15. This order states, in part, "Emergency provider will NOT provide: Perform chest compressions, insert advanced airways, administer cardiac resuscitation drugs, provide ventilator assistance, defibrillate." This order was signed by MD (Medical Doctor) F on 3/18/15. Resident 1's "Physician's Orders" dated 3/17/15 state, "No Code-DNR (do not resuscitate)."</p> <p>The facility completed "Misconduct Incident Report" for Resident 1's death. This document states, "Date Occurred: 3/30/15. Time Occurred: 3:30 AM. (Resident 1) was found on the floor non responsive. Resident was on 15 minute checks and the CNA had just checked him the client was last seen sitting on the side of his bed. The aide has placed his oxygen back on, as the client had removed it. She then went into another clients room to help reposition that client when she heard the bed alarm of (Resident 1), responded, say him on the floor and then went to get the nurse immediately. The nurse responding called a code, started CPR, paramedics responded. The</p>	F 155			

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F 155	Continued From page 3 client never did respond and death was called ...The resident was found non responsive on the floor, a code was called, 911 was notified, the facility nor paramedics were able to revive the resident." The facility completed interviews related to the incident. Interviews include: Certified Nursing Assistant (CNA) E: "At any time during your shift did you notice when any injury might have occurred? If yes, please describe: Only after fall. Saw resident on floor there was no response. Got nurse immediately." "Fall/Incident Evaluation/Assessment/Physician Notification/TPN" dated 3/30/15 states, "CNA went to room for 15 min checks, found resident prone on floor next to bed. Initial Assessment: VS (vital signs) Non responsive." "Treatment Progress Notes" dated 3/30/15 state, "0345 (3:45 AM): CNA called writer to resident's room-stated he was on the floor, not responding-Had CNA grab vitals machine. Writer called supervisor, went to room c (with) CNA & found resident face down on floor next to bed. CNA moved bed to get better access to resident. Writer moved over the bed table & fan. No response from resident. Together we rolled him to his back. 911 activated. Writer started chest compressions. CODE was called & supervisor brought crash cart. Pads applied to chest. Other nurses came to room to help. CNA got resident's chart which shows he's a DNR status. CPR was continued due to starting. Ambulance and deputies also on scene. After showing the paramedics the MD order that shows no CPR compressions were stopped. (MD F) paged prior to stopping CPR. Nurse supervisor talked to (MD F) when he returned page. (MD F) pronounced death at 0400 (4:00 AM) ...Rock County Sheriff's Dept. contacted the M.E. (medical examiner)	F 155			

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F 155	<p>Continued From page 4</p> <p>about the incident to get permission to move the body. Medical Examiner called back, spoke with writer at length about the incident, resident's medical history and who next of kin is ..." This note was written by RN C.</p> <p>The facility completed CPR on Resident 1 despite his wishes to not have CPR initiated.</p> <p>"PremierOne Report" which notes the details of the event on 3/30/15 states the following: "3:48:38 When asked if CPR was in progress, she said she was trying and disconnected ...4:46 AM: Long term care facility death, DNR band, medical examiner notified and said body could be released to funeral home."</p> <p>The above statement indicates that Resident 1 was wearing a DNR bracelet.</p> <p>Surveyor 27973 spoke with Director of Nursing (DON) B on 4/7/15 at approximately 2:00 PM. Surveyor 27973 asked DON B about the facility's policy for Code Blue and for explanation of the facility's current policy. DON B stated that it was not her expectation that staff not do CPR if there is not a DNR. DON B stated that this was a contraindication in the policy and that her staff is trained to do CPR if there is not a DNR order.</p> <p>Surveyor 27973 asked DON B about her expectations in the situation with (Resident 1). DON B stated that she would have expected that a Code Blue be called and at the same time, the chart be checked. Surveyor 27973 asked DON B if (Resident 1) had a DNR bracelet on. DON B stated that she could not say if he did or did not. DON B stated that she tells staff that they cannot be totally dependent on a wrist band. DON B stated that she would prefer that staff is double checking with the orders. DON B stated that this should be simultaneously done when an event is discovered. Surveyor 27973 asked DON B what she had done regarding (RN C), to ensure that it</p>	F 155			

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F 155	Continued From page 5 does not reoccur. DON B stated that [Nursing Home Administrator (NHA) A] did more of the investigation. DON B stated that the circumstances were unclear. DON B stated that she was not sure if (RN C) was confused about the incident, was it a fall or MI? DON B stated, "As a nurse, this might throw me." DON B stated that she did not talk to (RN C) about it. Surveyor 27973 spoke with NHA A on 4/7/15 at 10:30 AM. NHA A stated that she educated the one nurse involved in the incident and plans to educate others at the next meeting. At 1:20 PM, NHA A stated that the physician who ordered to stop the CPR was on the phone with paramedics as well as the nursing staff from the facility. Surveyor 27973 requested a listing of all residents in the facility noting CPR preference. The facility provided Surveyor 27972 with a listing indicating that 77 of the 117 residents wished to be DNR. Surveyor 29360 spoke with RN D on 4/7/15 at 10:30 AM. RN D stated that the residents may wear a wrist band or necklace that would indicate if they are a DNR and there would be an order for DNR in the chart. RN D stated that she would grab the chart and go or send someone to get the chart. RN D stated that if there was no band and nothing in the chart, then they would be treated as a full code, a code would be called and the crash cart would be obtained. RN D stated that she would start CPR and if she finds that they are a no code then she would stop compressions and check vital signs. RN D stated that if there was no pulse or breathing, she would stop.	F 155			