Citation Numb 6804	er:			Date: June 1,	2018	
Facility Name: Accura Healthcare Sioux City			Survey I 17 2018	Survey Dates: May 3-4 2018 – May 14- 17 2018		
Facility Address/City/State/Zip 3800 Indian Hills Drive						
Sioux City, IA		MW				
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date	

58.19(2)j	58.19(2) Medication and treatment. j. Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I,II,III)	1	\$7000 (Held in Suspension)	UPON RECEIPT
	DESCRIPTION:			
	Based on clinical record review, staff and physician interviews and facility policy review, facility staff failed to implement CPR (cardiopulmonary resuscitation) for one resident who desired CPR (Resident #4) of 24 residents sampled, which resulted in an immediate jeopardy to residents health and safety. The facility identified a census of 37 current residents.			
	Findings include:			
	1. According to the MDS (minimum data set) dated 2/28/27 Resident #4 had diagnoses that included hypertension, diabetes mellitus, hyperlipidemia, anxiety disorder, depression, chronic obstructive pulmonary disease,			

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respiratory failure, hypoxemia, muscle weakness, obesity and nicotine dependence. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact cognitive status. According to the MDS the resident required extensive assistance with bed mobility, dressing and toilet use and total dependence with transfers. The MDS identified the resident required oxygen therapy. The care plan dated 9/14/16 directed staff to provide CPR (cardiopulmonary resuscitation). Review of the Iowa Physician Orders for Scope of Treatment dated 2/21/14 revealed the resident requested CPR for no pulse and not breathing. The resident also requested Full treatment including intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated and included critical care. Review of the Order Summary Report dated		
1/1/18 through 4/30/18 revealed the order the resident a full code.		

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Resident mottled to hands and feet. No response. Did call 911 and the operator asked nurse if resident beyond help and staff reported that he had been. Will send paramedics to facility. Family planned to come to the facility later today to sign DNR (do not resuscitate) but currently a full code. The resident beyond any help. No response to any compressions. At 4:10 AM Paramedics arrive and asses and say to call funeral home if family had one arranged. Still not able to reach son, called and spoke with brother-in- law again and he to continue to try to reach son. Body cleaned, called Physician on call and received OK to send the body to funeral home. At 4:30 AM waiting for family to OK to		
arrive and asses and say to call funeral home		
law again and he to continue to try to reach		
and received OK to send the body to funeral		
call funeral home. Administrator notified.		
The facility identified a total of 17 residents with request for full code (CPR).		
During an interview with Staff A, CNA on 5/4/18 at 12:11 PM she stated she worked		
10:00 PM to 6:00 AM. She stated at approximately 3:40 AM she and Staff G, CNA		
went into the resident's room. Staff G put the pulse oximeter on his finger and Staff A had		

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 noticed he was not breathing. Staff A went to get Staff I, LPN and she checked his pulse. Staff I said yep he's gone and left the room and called the nurse on call. Staff I called the fire department and they came to the facility and went to the residents room. She further stated Staff I did not do chest compressions. She stated the resident's hands and lips had been purple in color and she noted a small bruise on his left shoulder. He had no discoloring anywhere else and had not been still when they cleaned him after he passed. During an interview with Staff G, CNA on 5/8/18 at 2:00 PM she stated she worked the 2:00 PM to 10:00 PM shift and the 10:00 PM to 6:00 AM shift. She stated after her lunch break she and Staff A went to the resident's room. When they went to the resident's room she checked his O2 sat and there had been nothing. Staff A went to get the nurse and she stayed in the room. Staff I came in and said he was gone and left the room to make phone calls. She stated she and Staff A cleaned the resident up the best they could. She stated his skin was cool and had a look about him. His color was gray and not 	
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normal. Jody stated Staff I checked James with a stethoscope and said he was gone. Staff G did not recall any purple discoloration. She stated it took approximately 20 minutes to finish cleaning him and then they went up to the desk. She stated she did not see Staff I do chest compressions did not come back into the room and she was gone quite a while.		
Review of the Time sheet for Staff G, CNA (Certified nursing assistant) revealed she ended lunch break at 3:35 AM.		
During an interview with Staff I, LPN on 5/4/18 at 2:30 PM she stated she had been in the resident's room approximately 20 to 30 minutes before he passed and he was asleep. 20 minutes later the CNAs called her in and he had been turning purple and mottled, had no heart rate and no		
respirations. She stated she knew his son was coming to sign DNR papers. She called the nurse on call and said it was pointless to call the ambulance. She said the resident had been mottled and started to stiffen. Staff I stated she started 1 or 2 chest compressions		

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and realized she would have to get on the bed or put the bed way down because the	
resident had been too large. She further	
stated she realized he was a full code.	
During an interview with the resident's	
physician on 5/17/18 at 8:30 AM he stated	
the resident had been able to make own	
decisions and chose to be a full code. He	
further stated within 7 minutes or so and staff	
visualized the resident he did expect them to	
provide CPR. If it had been 70 minutes or 7	
hour he would not expect CPR to be	
provided.	
Review of the Policy and Procedure titled	
Cardiopulmonary Resuscitation (not dated)	
directed the staff to do the following:	
a. In the event of a medical emergency	
during which cardiopulmonary resuscitation	
may be required, the nurse or other staff	
member certified in CPR will initiate CPR.	
Another staff member will dial 911 and	
access emergency licensed personnel to the	
facility to continue resuscitation and transport	
the resident to the hospital.	
b. CPR will be initiated an emergency	

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personnel summoned by calling 911 in the event that a resident has a cardiopulmonary arrest, unless (1) there is the presence of obviously clinical signs of irreversible death (dependent lividity or rigor mortis); or the resident or surrogate has indicated that resuscitation is not desired and the physician has issued a do not resuscitate (DNR) order which is located in the resident's clinical record. c. All licensed nursing staff will be required to be certified in CPR and be re-certified in a timely manner. Other staff that is currently certified may initiate or assist with CPR on residents designated as full code. d. All residents and their families and/or significant others will be informed of this policy upon admission to facility. Review of the Resident's Bill of Rights dated 11/16 directed staff to do the following: a. The facility must provide equal access to quality care regardless of diagnoses, severity of condition, or payment source. A facility must establish and maintain identical policies		

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plan for all residents regardless of payment source.		
Review of the Education dated 4/30/18 revealed staff educated on abuse/investigation procedure, corrective coaching who needs to know, lividity, rigor mortis and the American Heart Association CPR meeting.		
Review of the CPR in-service dated 5/11/18 revealed staff in-serviced on CPR- and full code status scenarios.		

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Facility Administrator

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