Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6794			**Date: April 25, 2018**
Facility Name: Ennoble Skilled N & R		**Survey Dates:** **March 29, April 11-13/2018**	
Facility Address/City/State/Zip **2000 Pasadena, Iowa 52001**	**MW**		

Rule or Code Section	Nature 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) **DESCRIPTION:** Based on clinical record review, facility policy review, staff and family interviews, the facility failed to provide CPR (Cardio Pulmonary Resuscitation) to one of four residents reviewed during the investigation. Resident #1 was found pulseless and without respirations and no CPR was initiated. The facility census was 63 residents and 21 of those residents had designated for full resuscitation. Findings include: The Minimum Data Set (MDS) assessment dated 3/26/2018, documented Resident #1 had diagnoses that included heart failure, diabetes mellitus, Parkinson's disease and received oxygen therapy. The MDS assessment documented the resident had moderately impaired cognitive skills and required extensive assistance to transfer and ambulate.	**I**	**$6750 (Held in Suspension)**	**UPON RECEIPT**

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	A facility Expression of Wishes form dated 3/19/18, documented the resident requested Full Code Status. The Power of Attorney form revealed the resident designated his/her spouse as his agent. The plan of care included Admission Baseline-Full CPR, monitor breathing pattern, oxygen saturation and respiratory rate. The Admission Nursing Assessment effective 3/19/18 included an intervention for full CPR. A Physician Order Report included an order for Full Cardiopulmonary Resuscitation (CPR) active 3/19/18. Progress Notes dated 3/26/18 at 9:17 p.m., documented Staff C, registered nurse, RN documented the resident experienced a possible change of condition and noted shortness of breath and other change in condition. Staff C notified the physician at 9:45 p.m. See SBAR for further information. At 9:55 p.m., Staff C documented the physician ordered 20 milligrams (mg) of Lasix now and increase oxygen to 3 liters per mask, monitor condition and if worsens, will need to evaluate at			

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	emergency room. Contact physician in morning with condition report. Staff C notified the resident's spouse and the spouse stated she noticed a decline today while visiting and would not be surprised if he ended up in the hospital, she thought he was giving up. Progress Notes dated 3/27/18 at 12:17 a.m., documented Staff C noted the resident had a large amount of incontinent urine and oxygen saturation level was at 80% with oxygen at 3 liters. The resident continued with productive cough of clear frothy phlegm and refused two times two to go to emergency room and stated what would they do anyway. Discussed at length and continued to refuse to go and stated he was not having trouble breathing. At 1:03 a.m., Staff C documented the resident was awake and alert with oxygen saturation at 80% and continued with productive cough with clear phlegm and denied shortness of breath. Staff C noted the resident had difficulty with conversation and refused to go to the emergency room and said they would just keep him. At 2:00 a.m., notes revealed Staff C checked the resident on rounds and had saturation at 80% with oxygen at 3 liters, head of bed elevated, no distress and sleeping.			

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	At 2:45 a.m., Staff C documented the resident had no pulse, blood pressure or apical. The resident had cyanotic and cool skin. Call placed to spouse who stated no CPR, the resident would not want it and it should have been changed. At 3:00 a.m., Staff C reported the resident's spouse arrived and said she knew the resident worsened the last few days and would not have wanted to go back to the hospital. The spouse again said the resident did not want CPR. At 4:45 a.m., the funeral home left with the resident's body. At 8:17 a.m., the DON notified the physician of the resident's passing. The SBAR (Situation, Background, Appearance, Review) Communication Form dated 3/26/18, documented Staff C documented the resident had a change in condition with symptoms of shortness of breath and other change in condition. Oxygen saturation at 76% at 2 liters, congested, clear frothy phlegm and cyanotic. Condition worse and nebulizer treatment given without improvement and movement and talking made symptoms worse. Vital signs: Blood pressure 135/72, pulse 63,			

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	respiratory rate 20, temperature 98.4, weight 259 pounds. Respiratory Evaluation: abnormal lung sounds, cough, labored or rapid breathing, shortness of breath and large amounts of clear frothy phlegm. Appearance: Worsening of COPD. Resident's Weights and Vital Summary included: Oxygen Saturations: 3/26/2018 at 9:21 p.m. -79% via nasal cannula 3/25/2018 at 10:18 a.m.- 90% 3/24/2018 at 7:46 a.m. - 90% Respiration Summary: 3/26/2018 at 1:44 p.m. - 20 breaths per minute 3/25/2018 at 9:54 p.m. - 19 breaths per minute 3/25/2018 at 10:17 a.m. - 20 breaths per minute Pulse Summary: 3/26/2018 at 1:44 p.m. - 63 beats per minute 3/25/2018 at 9:54 p.m. - 50 beats per minute 3/25/2018 at 10:17 a.m. - 58 beats per minute Temperature Summary: 3/26/2018 at 1:44 p.m. - 98.4 degrees Fahrenheit 3/25/2018 at 9:54 p.m. - 94.3 degrees 3/25/2018 at 10:17 a.m. - 97.3 degrees Blood Pressure Summary: 3/26/2018 at 1:44 p.m. - 135/72 3/25/2018 at 9:54 p.m. - 114/61 3/25/2018 at 10:17 a.m. - 101/52 A Physician progress note dated 3/26/18,			

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	revealed the resident appeared weak and fatigued and in a wheel chair. The resident's head hung forward and he failed to lift his head up to look at the physician. The resident had decreased lung sounds without rales or rhonchi, irregular but controlled heart rate, bilateral pedal edema and a small sore on the right lower shin that appeared to be healing. The resident had evidence of fluid overload and ordered Furosemide (diuretic) daily, and no signs of pneumonia. The resident had an appointment to see the cardiologist the following week. Timeline of Events included: On 3/26/18 at 1:25 p.m., the resident returned from the physician's office with new orders for Lasix 40 mg (milligrams) and Potassium 20 mg daily. Laboratory tests done at office. At 2:03 p.m., laboratory tests received with new orders for Kayexalate 15 grams times two doses; clarification with physician returning call at 6:07 p.m., physician changed orders to discontinue potassium and give one dose of Kayexalate today and one dose tomorrow. At 9:17 p.m., noted change of condition by charge nurse (shortness of breath). Physician notified.			

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	At 9:55 p.m., on call physician notified, new orders received, call placed to spouse (POA) with notification of change of condition. At 11:00 p.m., Charge nurse did vital signs and stated resident resting in bed with no distress. On 3/27/18 at 12:27 a.m., charge nurse assessed resident again, resident refused to go to the emergency room and had no complaints of difficulty breathing. Charge nurse again asked resident to go to the emergency room and again refused. At 1:03 a.m., charge nurse checked oxygen saturation, again asked resident to go to the emergency room and he refused. At 2:00 a.m., charge nurse and Certified Nurse Aide, CNA assisted with incontinence care, checked vitals and no distress noted. At 2:45 a.m., CNA found resident unresponsive, paged for charge nurse and nurse responded. Resident was cold and cyanotic with no radial pulse or breaths noted. Nurse ran to telephone residents spouse to inform that CPR needed to be initiated. Wife stated definitely not, no CPR, resident would not want that, it should have been			

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	changed. The facility layout revealed the resident's room A-8 had three other resident rooms, two utility storage rooms and an activity storage room between it and the nurse's station on A Hall. During interview on 4/11/18 at 9:15 a.m., the resident's spouse reported she last visited the resident on 3/26/18 at the facility and left at approximately 2:30 p.m. The facility contacted her early in the morning and reported they had called the physician and started the resident on Lasix, a diuretic. The nurse asked if they should send the resident to the hospital. The spouse indicated the resident made those decisions and apparently he did not want to go when the nurse asked. The resident told the spouse several times that he did not want to go to the hospital and did not want to go through all of that again. The resident had Parkinson's disease for several years. Around 3 o'clock in the morning the facility called the spouse again and said the resident had just passed away and what did she want to do, did she want to go to the facility. The spouse went to the facility and staff assisted with funeral arrangements. The nurse had asked if the spouse wanted the resident to have CPR. The spouse indicated it was the resident's wishes not to have CPR if he could not survive. The spouse			

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	told the nurse the resident did not want to be saved, did not want to go to the hospital and to let him rest. When the resident told the spouse about CPR, he said only if he could survive, only if it would help him live longer. The resident did not want to be put on machines. The resident had a pacemaker and the spouse thought that could be an issue. The spouse said the resident was tired of fighting it, just gave up. The spouse said the facility never called after notifying her of the new order for Lasix until they called when the resident passed away. The spouse revealed had she known of the resident's worsened condition, she may have told them to go ahead and send the resident. During interview on 3/29/18 at 12:30 p.m., Staff A, Administrator reported the resident passed away and his full code status had not changed since admission on 3/19/18. Staff C, RN worked from 6 o'clock p.m. on 3/26/18 until 6 o'clock a.m. on 3/27/18. During the night shift, Staff C noted the resident had a change in condition, assessed the resident and notified the physician and received a new physician order. Staff C notified the resident's spouse. Staff asked the resident to go to the emergency room, but the resident refused. The resident's spouse said she felt the resident was giving up. The resident's oxygen saturation level measured 80%. Staff C checked			

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	on the resident frequently. At approximately 2 o'clock a.m., Staff D, CNA and Staff C provided cares for the resident and at 2:45 a.m. Staff D observed the resident without respirations. Staff C knew the resident had a full code status, the resident appeared cold and cyanotic and called the spouse. The spouse said not to start CPR; the resident would not want it. Staff A and Staff B, DON (Director of Nursing) interviewed Staff C and suspended her and reported it to the Iowa Board of Nursing, Staff B educated all nurses before they stepped onto the floor. They also did an audit on all residents and their code status. Staff C checked the resident's code status around midnight that night and knew he was a full code. During interview on 4/11/18 at 2:20 p.m., Staff B, DON revealed the facility suspended Staff C for not following the CPR policy and not notifying the physician of the resident's worsened condition. The resident's oxygen saturation level read 80%. Staff C said she kept a close eye on the resident and asked the resident if he wanted to go to the emergency room but the resident refused. Staff D, CNA called Staff C immediately upon observation. Staff B educated all nurses on 3/27/18 regarding the CPR policy, assessment after a significant change and the completion of vital signs. The facility did an audit of all resident's code status.			

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	During interview on 3/29/18 at 2:43 p.m., Staff C, RN reported she worked at the facility for three years. On 3/26/18 staff assisted the resident to bed. The resident had his own machine for measuring oxygen saturation and it read 76%. Staff C assessed the resident and administered a breathing treatment without a change in condition and she notified the physician. The physician ordered Lasix and to increase the resident's oxygen to 3 liters. The physician told Staff C if the resident's symptoms get worse, he suggested the resident go to the emergency room. Staff C explained to the resident what the physician wanted him to go to the emergency room if he did not improve. The resident said he did not want to go. At midnight Staff C and Staff D provided cares and the resident's oxygen saturation read 80% and he coughed up phlegm. The resident said he was fine. Staff C encouraged the resident to go to the emergency room, but the resident refused. Earlier when Staff C called the resident's spouse, she said the resident had not felt well. Staff C told the spouse the resident should go to the hospital and the spouse indicated she was not surprised. At approximately 2 o'clock a.m., Staff C and Staff D provided cares, the resident's oxygen saturation read 80% and the resident slept. The resident's fingernails did not appear bluish at that point and the resident woke up			

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	when they provided cares. At approximately 2:45 a.m., Staff D called Staff C to the resident's room as she thought the resident had passed. Staff assessed the resident and found the resident stiff and no pulse. Staff C ran to the desk and called the spouse. Staff C reported she knew the resident was a full code but he was cold and stiff. Staff C told the spouse they could start CPR and call 911 and the spouse told Staff C no, he would not want that. Staff C revealed the CPR policy required staff to start CPR on a resident with a full code status. Staff C felt since the spouse said not to do CPR, she did not do it. Staff C indicated if she knew the resident was near death, she would have sent the resident. But, the resident seemed alert and did not show signs such as blue fingernails and appeared to be doing better. If Staff C had known, she would have called the spouse and said they needed to send the resident and the spouse probably would have gone along with it. When the spouse came to the facility after the resident passed, Staff assisted her with funeral home arrangements. Staff C received a write up and education, she knew the policy but thought the spouse made the call. The facility suspended Staff C from work. Staff C reported she felt bad and realized she should have done CPR. Upon hire, she reviewed the CPR policy.			

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	During interview on 4/11/18 at 3:35 p.m., Staff C revealed when she assessed the resident on 3/27/18 the resident sat upright with the head of bed elevated. Staff C observed the resident felt cool and had cyanotic fingernails and mouth. Staff C grabbed the resident's right and left wrists and found no pulse. Staff C put her head and hand on the resident's chest and failed to feel respirations or hear a heartbeat. Staff C had no stethoscope with him/her at the time. The resident's eyes were half open and glassy. Staff C reported she just checked radial pulse and respirations. The bed sheet covered the lower extremities. The resident sat up just like they left him approximately 30 minutes prior. Staff B could tell when she picked up the resident's wrists that the resident was abnormally and moderately stiff, and limp with no physical response at all. The hands, fingernails and mouth were bluish/purple and all over pale and cold. Staff C knew the CPR policy and knew the resident had a full code status. If the spouse had requested CPR, Staff C would have provided it. During interview on 4/11/18 at 11:40 a.m., Staff D, CNA reported working on 3/26/18 at 10 o'clock p.m. until 3/27/18 at 6 o'clock a.m. When Staff D arrived at the facility she heard in report the residents oxygen saturation levels fluctuated and he needed to frequent checks. Staff D reported			

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	the resident appeared lethargic and complained of being hot and reported it to Staff C. Staff D opened the resident's window and covered him/her with a sheet. Staff C frequently asked the resident if he wanted to go to the hospital and the resident refused. At approximately 2 o'clock a.m. Staff D and Staff C provided cares and repositioned the resident. A half hour later, Staff D entered the resident's room and the resident had passed away. Staff D observed the resident lifeless, cold to the touch and when Staff D placed her hand on the resident's stomach, she felt no movement. Staff D called Staff C to the room. Staff D observed Staff C look at the resident, feel the resident's wrists and said yes, he was dead. Staff C called the resident's wife. Staff D reported she had no knowledge the resident had a full code status. Staff C never revealed the resident's code status or what the spouse said. Staff C and Staff D prepared the body, the resident's spouse arrived and they assisted with finding a funeral home. During interview on 4/11/18 at 12:48 p.m., Staff D revealed at 2:30 a.m., the resident's head drooped down and Staff D felt no respirations. After Staff C called the resident's spouse, Staff D and Staff C pulled the bed sheet back and moved the resident. The limbs were stiff and the residents face and legs appeared purple. They			

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	placed the resident's arms up on his/her chest, they had to bend them at the elbow, not horribly difficult but stiff. During interview on 4/11/18 at 11:10 a.m., Staff F, RN reported working from 6 o'clock p.m. on 3/26/18 until 6 o'clock a.m. in 3/27/18 in the back section of the building. Staff C worked the front section and never called a code, and never informed Staff F of the residents passing. Staff C told Staff F the resident had passed and the spouse was on the way. Staff F reported the CPR policy required staff to initiate CPR of full code residents no matter what, even if the resident had clearly passed away, until Emergency Medical Services (EMS) arrived and took over, or the power of attorney tells them to stop. All staff were re-educated regarding the policy. During interview on 3/29/18 at 2 o'clock p.m., Staff G, Licensed Practical Nurse, LPN reported working on 3/26/18 during the day shift. The resident went to the physician during the day and appeared normal. The resident's profile documented the code status. All staff knew where to look for code status and knew to initiate CPR on a resident with full code status, direct someone to call 911 and do not stop until paramedics arrive. The DON provided re-education for all staff regarding CPR and code			

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	status. During interview on 3/29/18 at 1:50 p.m. Staff H, LPN reported staff was to initiate CPR after checking if you are not sure, even if the resident obviously passed away until EMS arrives. The DON re-educated all nurses regarding initiating CPR. When the resident was admitted, Staff H asked the resident and his spouse about the full code status. The spouse said the resident had a full code status and they were working on it. Staff H directed them to discuss it with the social worker if needed. During interview on 4/12/18 at 9:05 a.m., Staff I, Social Worker reported she reviewed admission paper work with the resident and read the facility Expression of Wishes form and repeated it again to ensure the resident understood the question. The resident electronically signed the form and requested full code status. The spouse did not say anything. The resident was alert and oriented. The facility Education Campus, nursing - licensed only form revealed on 3/27/18 nurses received the following education: Recognizing and Responding to CPR - Full Code, instructed by the DON.			

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	Subject: Cardiopulmonary Resuscitation (CPR), approved by Huey Lin, MD, effective date 1/1/2014. Policy: Facility clinical staff shall respond immediately to all notifications of patient arrest and need for resuscitative interventions. All licensed Respiratory Care Practitioners (RCP's)and Nursing of facility may perform CPR services under the general supervision of the physician. All RCP's, RN's and LVN's must be certified as Providers of Basic Life Support, either by the American Heart Association or the American Red Cross. To Call Code Blue in the facility: When a patient shows signs of cardiac or respiratory arrest, Code Blue must be called, unless a specific written order by the physician states that a code shall not be called. Clinical staff shall perform the following when calling a Code Blue: If the patient shows no pulse or sign of respiration, Code Blue must be called.			

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	CPR must be initiated immediately when the Code Blue has been called. The Code Blue Team shall respond once the call has been made. Regardless of how long the patient may have been in this condition, CPR must be initiated at once after the condition has been discovered. Note; The attending physician must be notified that CPR has been performed. This is the RN's responsibility. Effective immediately, 3/27/18 included: a. Nurses will not copy and paste assessments b. Nurses will do your own vital signs on every assessment you need to complete skilled, etc. c. Vital signs on your assessment will be current (day of the assessment) d. Nurses will have stethoscope on them at all times. e. Change in condition - need to re-evaluate condition and document findings until patient is stable, include vital signs, notify MD again if condition not improving and document it, notify DPOA (Durable Power of Attorney) again if condition not improving and document it and if full code may want to contact DPOA and have them change it. f. Full code - you start CPR immediately, you can have another staff member call 911 and then the DPOA to see if they still want CPR even after the			

Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6794			**Date: April 25, 2018**
Facility Name: Ennoble Skilled N & R		**Survey Dates: March 29, April 11-13/2018**	
Facility Address/City/State/Zip **2000 Pasadena, Iowa 52001**			
	MW		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	patient is found deceased g. Braden and Skin Assessments - signing them off on the eMAR (medication administration record) and not completing them in PCC (Point Click Care). The facility Quality Improvement Action Plan included: a. Quality Deficiency - Not performing CPR on a full code status patient Interventions/Action Steps - MD notified, DIA (Department of Inspections and Appeals) notified, Ombudsmen notified, Iowa Board of Nursing notified, Investigation initiated, Licensed nurse suspended, Licensed nursing employees re-educated on policy of CPR full code patients will have CPR initiated immediately if patient found without a pulse and audits to be completed for 8 weeks. Responsible persons - DON and Administrator Target Date - 5/25/18 b. Quality Deficiency - Not completing comprehensive assessment or documentation after significant change with no improvement, not taking complete vital signs. Not notifying MD or DPOA after significant change with no improvements and copy and pasting assessments and vital signs, not day of			

Facility Administrator Date

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	assessment. Interventions/Action Steps - Patients with current condition changes have been reviewed, licensed nursing employee's re-educated on Interact 3.0 and Promoting Effective Communication and Coordination of Care, and audits completed for 8 weeks by the DON. Target Date - 5/25/18 **FACILITY RESPONSE:**			

Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).