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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395740	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/11/2022
NAME OF PROVIDER OR SUPPLIER: West Chester Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 West Miner Street West Chester, PA 19382	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33840 Based on a review of established guidelines for CardioPulmonary Resuscitation (CPR), the facility's policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that CPR was provided in accordance with established facility policy and procedure for one of five residents reviewed (Resident R1), creating a situation in which the residents were placed in Immediate Jeopardy related to failing to perform cardiopulmonary resuscitation and lack of knowledge on where to locate a resident's code status for 28 residents that had cardiopulmonary resuscitation orders. Findings include: Guidelines from the American Heart Association (AHA), dated 2020, revealed that the AHA urged all potential rescuers to initiate CPR unless a valid Do Not Resuscitate (DNR) order was in place; if there were obvious clinical signs of irreversible death present, including rigor mortis (stiffness of the limbs and body that develops 2 to 4 hours after death and may take up to 12 hours to fully develop), dependent lividity (reddish-blue discoloration of the skin resulting from the gravitational pooling of blood in the lower lying parts of the body in the position of death), decapitation (separation of the head from the body), transection (division by cutting across the body), or decomposition (decay); or if initiating CPR could cause injury or peril to the rescuer. The facility's policy regarding CPR, dated [DATE], states that if a resident was found unresponsive and not breathing normally, CPR would be initiated unless there was at least one obvious signs of irreversible death (lividity or pooling of blood in dependent body parts, hardening of muscles or rigidity, or injuries incompatible with life). If there are no obvious clinical signs of irreversible death, and there is no visual identification of a DNR order, CPR should be initiated. Call 911 and notify the primary physician and continue CPR until a DNR order is given by the physician, the patient is revived, or emergency medical services arrive and take over the care. Review of Resident R1's clinical record revealed the resident was admitted on [DATE] and a Physician's order for Full Code (life sustaining interventions including resuscitation) was written on [DATE]. (continued on next page)

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.

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the clinical record revealed a nursing note dated [DATE] by Licensed Employee E3 stating the resident was seen at 0530 the call light was activated. The nurse aide called for assistance to roll the resident to put her pillow back under head. While changing the resident's position, (Licensed Employee E3) noted resident had watery eyes and sudden change in breathing. The (Licensed Employee E3) called for the supervisor and went to get the oxygen. On the way back to the room the aide yelled that the resident stopped breathing. Continued review revealed a nursing note dated [DATE] by Registered Nurse Employee E4 that indicated, (I) was called to the room at 6:18 a.m. and the resident was found in bed unresponsive to verbal or external stimuli. No respirations, apical heartbeat absent x 1 minute, no radial pulse, pupils fixed and dilated. Resident pronounced dead. There was no documented evidence that the resident was provided CPR in accordance with the code status or with the facility policy that states if the resident is found in cardiopulmonary arrest (no apparent pulse, blood pressure, or respirations) CPR will be initiated until there is a DNR order, or a physician's order not to administer CPR or EMS arrive. A telephone interview conducted on [DATE] at 1:10 pm by the surveyor with the Licensed Employee E3 revealed Employee E3 was unaware of the code status of Resident R1 and indicated uncertainty of where to find the code status of any resident. Licensed Employee E3 indicated CPR was not initiated. When questioned why life sustaining interventions were not initiated, Licensed Employee 3 responded, the resident was already dead. Licensed Employee E3 reported they have not worked at the facility since the event. Review of facility documentation revealed an interview conducted with the Registered Nurse, Employee E4, on [DATE] by facility staff indicating Resident R1 was found in bed unresponsive to verbal or external stimuli. No respirations, apical heartbeat absent x 1 minute, no radial pulse, pupils fixed and dilated. Resident pronounced dead at 6:20 a.m. Surveyor did not receive a return phone call for further questioning. Interview with the Nursing Home Administrator and the Director of Nursing on [DATE] at 11:00 a.m. revealed that they were aware that staff did not provide CPR to Resident R1 in accordance with the code status, and the facility's policy. On [DATE], at 3:42 p.m. the Nursing Home Administrator was informed that the health and safety of residents were in Immediate Jeopardy due to the Licensed staff failing to provide CPR in accordance with a resident's physician's order and the facility policy and the lack of knowledge on how to locate the code status of residents. The facility submitted an acceptable immediate action plan on [DATE], at 6:29 p.m. that included the following actions: A facility wide sweep ensuring each resident's advanced directive and physician-ordered code status was in place. The facility developed an education plan for all licensed nurses regarding the facility's CPR policy and the signs of irreversible death; to ensure that CPR will be provided in accordance with each resident's advanced directive and physician orders and further education on where to find the code status of residents. The plan also included to actively hold Code Blue drills (simulated event whereby staff respond to a resident experiencing cardiac arrest) with staff, and to complete ongoing audits. (continued on next page)

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	395740	A. Building B. Wing	01/11/2022

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy was lifted on [DATE], at 2:32 p.m. when it was confirmed that the facility provided licensed nursing staff with education regarding providing CPR in accordance with residents' advanced directives, physician's orders and the facility's policy, location of code status and completed a Code Blue drill to ensure that licensed nurses were prepared to respond to situations that required CPR. Any remaining staff were scheduled to receive the education prior to the start of their next shift. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 201.18(e)(3) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 33840 Based on a review of their job descriptions it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure that Cardio Pulmonary Resuscitation was provided in accordance with the facility policy and procedures to residents that are a full code. Findings include: Review of the job description for the NHA revealed the essential function is responsible for planning and is accountable for all activities and departments of the Center subject to rules and regulations (put into affect) by government agencies to ensure proper healthcare services to residents. Review of the job description for the DON revealed the responsibility of the job position is overall accountability for providing leadership, direction and administration of day-to-day operations associated with direct patient care activities, nursing practice, clinical education and development, including continuing improvement in nursing services and to staff to meet patient/residents and their families' needs and expectations. The findings in this report identified that the facility failed to ensure that CPR was provided in accordance with the facility policy and procedures to residents that are a FULL CODE. The NHA and DON failed to fulfill their essential job duties that the federal and state guidelines and regulations were followed. Refer to F678 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 207.2(a) Administrator's Responsibility 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa. Code 211.12(d)(2)(3) Nursing Services