STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235458	A. Building B. Wing	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Grand Rapids	1950 32nd St S E Grand Rapids, MI 49508

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation pertains to Intake # MI00141034. Based on interview, and record review, the facility failed to honor an advance directive and the resident's right to refuse treatment in 1 of 5 residents (Resident #108) reviewed for code status/Cardiopulmonary Resuscitation (CPR), resulting in CPR being performed on a resident with a status of Do Not Resuscitate (DNR). Findings include: Review of an Admission Record revealed Resident #108 was a male, with pertinent diagnoses which included stroke, respiratory failure, atrial fibrillation (an irregular heart rate that results in poor blood flow), anemia, and high blood pressure. Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, out of a total possible score of 15, which indicated moderate cognitive impairment. Review of a DO-NOT-RESUSCITATE ORDER form for Resident #108, dated [DATE], revealed .I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me .This order is in effect until it is revoked as provided by law . This form was signed by Resident #108's Guardian and two witnesses on [DATE], and Resident #108's physician on [DATE]. Review of an Order Summary Report for Resident #108 revealed the physician order .DNR-Do Not Resuscitate . with a start date of [DATE] and no end date. Review of a Care Plan for Resident #108 revealed the focus .(Resident #108) admitted to facility with POA (Power of Attorney) for Health Care. Request to limit treatment form filled out indicating residents wishes . with interventions which included .CODE STATUS: DNR . and .Follow the limited treatment sheet and advanced directives as written per residents wishes . all initiated [DATE]. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurse's Note for Resident #108, dated [DATE] at 3:26 PM, revealed .Charge Nurse on (Unit Name) came to get this writer on (Unit Name) .Charge Nurse requested RN (Registered Nurse) to pronounce resident. Resident is a DNR code status and on Hospice services. When writer entered the room. Eyes were closed, no breathing or respirations noted. Auscultated chest, no apical pulse. Charge Nurse is notifying Hospice and family. Writer informed DON (Director of Nursing) and Administrator . Review of a Nurse's Note for Resident #108, dated [DATE] at 5:41 PM, revealed .Clinical team identified DNR form without physician signature. While seeking clarification of code status, DON and charge nurse initiated CPR on resident at (3:31 PM). 911 was contacted. Code was discontinued when completed DNR form was located. Code was stopped and resident pronounced dead at (3:41 PM). POA and hospice were notified of time of death and hospice came out to make funeral home arrangements . In an interview on [DATE] at 10:33 AM, Assistant Director of Nursing (ADON) D reported on [DATE] at approximately 3:30 PM, she pronounced Resident #108's death with Agency LPN AA. ADON D reported Resident #108 was listed as a DNR in his electronic medical record. ADON D reported in regard to why CPR was initiated on Resident #108 .Somebody accidentally uploaded (a DNR form) that was incomplete . ADON D reported there were two DNR forms uploaded to Resident #108's electronic medical record, and stated . They got confused because there was one that was incomplete .That was why CPR was initiated . In an interview on [DATE] at 10:49 AM, Director of Nursing (DON) B reported Resident #108 was on Hospice and had a code status of DNR. DON B reported around the time of his death on [DATE], the facility was in the process of auditing the charts to double-check the code status paperwork. DON B reported when they were notified of Resident #108's passing, Admission Counselor X checked his chart and identified a DNR form with no physician signature. DON B stated .upon seeing that we treated (Resident #108) as a Full Code until we could clarify . DON B reported CPR was initiated on Resident #108 while .the rest of the team dug into the chart and found the completed (DNR) form .That is when we were able to stop CPR . In an interview on [DATE] at 11:28 AM, Agency LPN AA reported Resident #108 was on Hospice, and passed away on [DATE] right around shift change in the afternoon, at approximately 3:30 PM. Agency LPN AA reported Resident #108 had been declining and stated .He was not doing well and we knew he was going to go very soon . Agency LPN AA reported after he passed, she obtained ADON D to pronounce his death. Agency LPN AA stated after pronouncing Resident #108's death .Somebody said his DNR (form) wasn't signed . Agency LPN AA reported due to this, CPR was initiated on Resident #108. Agency LPN AA stated that ultimately the situation was a .miscommunication . and stated .He actually did have a current DNR (order) . In an interview on [DATE] at 12:20 PM, Admission Counselor X reported on [DATE] she was asked to complete an audit of the DNR paperwork for residents at the facility. Admission Counselor X reported that during the audit, she had noted Resident #108 had a one page scan that wasn't signed, and had circled his name to go back to him later. Admission Counselor X reported when she discovered Resident #108 had expired, she immediately notified DON B of the incomplete paperwork and CPR was initiated. Admission Counselor X reported once the completed DNR paperwork was located in Resident #108's medical record, CPR was discontinued. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy/procedure Do Not Resuscitate, dated [DATE], revealed .The purpose of this policy is to provide a guideline to prehospital providers, who under certain circumstances may accommodate patients who do not wish to receive and/or may not benefit from cardiopulmonary resuscitation. This policy is drafted in accordance with Public Act 368 of 1978, as amended, as well as Act 192 and 193 of the Public Acts of 1996 and amended, effective February 4, 2014. This policy is intended to facilitate kind, humane, and compassionate service for patients who have executed a valid Do-not-resuscitate order under the aforementioned Acts .Do-not-resuscitate order - means a document executed under Public Act 193 of 1996, as amended, directing that if an individual suffers cessation of both spontaneous respiration and circulation in a setting outside of a hospital, resuscitation will NOT be initiated .

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(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** 36221 This citation pertains to Intake # MI00141034. Based on interview, and record review, the facility failed to perform Cardiopulmonary Resuscitation (CPR) on a resident with a Full Code status, in 1 of 5 residents (Resident #105) reviewed for code status/CPR, resulting in an Immediate Jeopardy when on [DATE] at approximately 9:00 AM Resident #105, who was designated as a Full Code, was found to be non-responsive (no respirations/heart beat). Licensed Nursing staff did not initiate CPR per physician order and facility policy, and Resident #105 passed away. This deficient practice placed all residents, who are designated as a Full Code and who suffer cardiac arrest, or are found non-responsive, at risk for serious harm and/or death. Findings include: Review of an Admission Record revealed Resident #105 was a female, with pertinent diagnoses which included stroke, diabetes, dementia, high blood pressure, right tibia fracture, vascular disease, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Review of a Request to Limit Treatment form for Resident #105, dated [DATE], revealed the statement .In the event of cardiopulmonary arrest, I wish to be given CPR . had a check mark in the section which stated .I DO . Further review of this form revealed the statement .You will remain a full code until this form and an order is obtained by the physician . This form was signed by Resident #105 on [DATE]. Review of an Order Summary Report for Resident #105 revealed the physician order .CPR-Full Code . with a start date of [DATE] and no end date. Review of a Care Plan for Resident #105 revealed the focus .(Resident #105) admitted to facility as her own responsible party. Request to limit treatment form filled out indicating (Resident #105's) wishes . with interventions which included .CODE STATUS: FULL CODE . both initiated [DATE]. Review of a Nurse's Note for Resident #105, dated [DATE] at 1:17 PM, revealed .Resident expired this morning (at) approximately (9:10 AM). No carotid or peripheral pulse. Pupils fixed and nonreactive (sic). No response to tactile stimuli. No respirations for full minute. Verified with second nurse and unit manager. DPOA (Durable Power of Attorney) notified (at) approximately (9:20 AM) . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 10:39 AM, Licensed Practical Nurse (LPN) S reported on [DATE], at approximately 9:00 AM, she was passing medications on the hall when she was approached by Registered Nurse (RN) L, who asked if she had a stethoscope and could come with her to verify Resident #105 had expired. LPN S reported Resident #105 did not have a pulse and was not breathing. LPN S reported RN L never discussed or mentioned Resident #105's code status. LPN S reported after she verified Resident #105's death she returned to her hall to continue with medication pass. LPN S reported CPR was not initiated on Resident #105. In an interview on [DATE] at 11:02 AM, Resident Care Assistant (RCA) F reported she was assisting Resident #105's roommate on [DATE] at approximately 9:00 AM, with the curtain pulled, when Physical Therapy Assistant (PTA) II requested her assistance with Resident #105. RCA F reported she went over to assist PTA II and observed that Resident #105 was not breathing. RCA F reported she and PTA II notified RN L, who was right outside the doorway, to come and assess Resident #105. In an interview on [DATE] at 11:24 AM, PTA II reported she initially approached Resident #105 for therapy on [DATE] at approximately 8:30 AM. PTA II reported at that time Resident #105 appeared to be asleep with her eyes closed, and was breathing. PTA II reported she left, and when she returned to Resident #105's room at approximately 9:00 AM, Resident #105 was non-responsive and .was clearly gray (in color) . and not breathing. PTA II reported she requested RCA F to assist because .I just wanted to make sure. Am I seeing what I'm seeing . PTA II reported after RCA F came over to Resident #105's side of the room, they immediately notified RN L who .was right outside the door . PTA II reported she asked RN L about Resident #105's code status, and RN L reported she wasn't sure. PTA II reported she also went down to notify Unit Manager M that Resident #105 was non-responsive and not breathing. PTA II stated when RN L and Unit Manager M were in Resident #105's room .they were questioning how long she had been deceased . PTA II reported CPR was not initiated on Resident #105. In an interview on [DATE] at 11:41 AM, RN L reported she was Resident #105's assigned nurse on [DATE]. RN L reported she was approached by PTA II at approximately 9:00 AM while at her medication cart. RN L reported PTA II told her she believed Resident #105 had expired. RN L reported Unit Manager M and LPN S came into Resident #105's room with her to assess the situation. RN L reported she listed to Resident #105's heart and lungs and didn't hear a heartbeat or note any respirations for a full minute. RN L reported this observation was verified by LPN S. RN L reported at that time they pronounced Resident #105's death. RN L reported she could not recall if Resident #105's code status was discussed. RN L reported she checked Resident #105's code status on her paper report sheet when PTA II notified her of Resident #105's status and stated .She was a Full Code . but reported she would need to verify in the computer. RN L reported she did not check the computer to verify Resident #105's code status. RN L stated she did not initiate CPR on Resident #105 because .I saw (Resident #105) and how pale she was (She) appeared to have been dead for a while . RN L reported she used her .nursing judgement . and .realized CPR would have done more harm than good . In an interview on [DATE] at 12:29 PM, LPN Y reported if a resident is found non-responsive (no breathing/no heart beat), nursing staff should quickly check the resident's code status in the electronic medical record. LPN Y reported if the resident is a Full Code, staff are to announce a Code Blue overhead, and initiate CPR. LPN Y reported CPR was not initiated on Resident #105 on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 12:55 PM, Director of Nursing (DON) B reported she was notified that Resident #105 had expired during morning meeting on [DATE]. DON B reported she left the meeting and went down to Resident #105's room to .just see the situation . DON B reported when she arrived, Resident #105 was covered up and postmortem care had already been completed. DON B reported she interviewed RN L, who explained what had happened. DON B reported she asked about Resident #105's code status, and discovered Resident #105 was a Full Code. DON B reported she asked RN L if CPR had been initiated and . She said no . DON B reported she asked Unit Manager M why CPR wasn't initiated when Resident #105 was a Full Code, and was told that Resident #105 had expressed a desire to be on Hospice. DON B stated . (Resident #105) wasn't yet on Hospice and there was no documentation of her transition to Hospice . DON B reported CPR should have been initiated when Resident #105 was found non-responsive on [DATE]. In an interview on [DATE] at 1:41 PM, Unit Manager M reported she was notified by a therapist on [DATE] at approximately 9:00 AM that there was an issue with Resident #105. Unit Manager M reported she responded with RN L and LPN S to Resident #105's room. Unit Manager M reported RN L and LPN S pronounced Resident #105's death, and she (Unit Manager M) notified DON B of her passing. Unit Manager M reported she did not recall a discussion with RN L or LPN S about code status, and stated .I didn't know the code status . Unit Manager M reported CPR was not initiated on Resident #105. Review of the policy/procedure Cardiopulmonary Resuscitation, dated [DATE], revealed .It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR) .The facility will follow current American Heart Association (AHA) guidelines regarding CPR .If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) . On [DATE], Administrator A was notified of an Immediate Jeopardy that began on [DATE] when the facility failed to perform CPR on a resident with a Full Code status (Resident #105) upon identifying that the resident was non-responsive (no respirations/heart beat). On [DATE], this surveyor verified the facility completed the following to remove the Immediate Jeopardy: 1) Resident #105 is deceased as of [DATE]. 2) On [DATE] the facility Medical Director was notified of the incident. 3) On [DATE] deaths that occurred within the last 90 days were reviewed to ensure advance directives were adhered to. Audit identified no concerns. 4) On [DATE] Registered Nurse who did not perform CPR on the full code status resident was immediately re-educated. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5) On [DATE] Education for all facility and agency nurses was initiated on the Cardiopulmonary Resuscitation (CPR) and the Do Not Resuscitate Policies. Any nurse not educated before [DATE] has been educated prior to returning to work. As of [DATE], 17 out of 24 actively working facility nurses were re-educated; those not educated by [DATE] have been re-educated prior to starting their next shift. As of [DATE], 23 out of 23 actively working facility nurses have been re-educated. As of [DATE] 100% of agency nurses have been educated prior to start of shift. 6) The Director of Nursing or Designee will complete audits on random nurses to determine if they are aware of the DNR and CPR policy. Audits will be done on 5 nurses weekly for 4 weeks, Biweekly for the next 4 weeks and once the following month. Any concerns related to code status documentation will be addressed immediately and reported to the Director of Nursing. The Director of Nursing will report results to QAPI monthly x3 months and then as directed by the QAPI committee. On [DATE] and [DATE] weekly audits were conducted. 7) The Director of Nursing or Designee will perform one code blue drill weekly on random shifts for 4 weeks to ensure all shifts have been evaluated, biweekly for the next 4 weeks, and then monthly going forward. Findings will be reviewed at the monthly QAPI meeting. On [DATE] and [DATE] code blue drills were conducted. 8) Audit results will be reviewed by QAPI until such time consistent substantial compliance has been achieved as determined by the QAPI committee. On [DATE], the QAPI committee reviewed the facility abatement plan, past non-compliance, and accompanying audits. 9) The Director of Nursing is responsible for attaining and sustaining overall compliance with this plan of correction. Date of Compliance with this regulation is by [DATE]. The facility was granted a Past Non-Compliance at the time of exit due to no further like incidents had occurred, the facility re-trained pertinent staff, the Cardiopulmonary Resuscitation (CPR) and Do Not Resuscitate policies were reviewed and deemed appropriate, and the facility had achieved sustained compliance. Therefore, no plan of correction will be required.