F678
(Rev.)

§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

INTENT
To ensure that each facility is able to and does provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physicians orders, such as DNRs, and the resident's advance directives.

DEFINITIONS
"Advance directive" is defined as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. 42 C.F.R. §489.100. Some States also recognize a documented oral instruction.

"Basic life support" is a level of medical care which is used for victims of life-threatening illnesses or injuries until they can be given full medical care at a hospital, and may include recognition of sudden cardiac arrest, activation of the emergency response system, early cardiopulmonary resuscitation, and rapid defibrillation with an automated external defibrillator, if available.

"Cardiopulmonary resuscitation (CPR)" refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased.

"**Code Status**" refers to the level of medical interventions a person wishes to have started if their heart or breathing stops.

"**Do Not Resuscitate (DNR) Order**" refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. Existence of an advance directive does not imply that a resident has a DNR order. The medical record should show evidence of documented discussions leading to a DNR order.

GUIDANCE
In keeping with the requirement at §483.24 to "provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident" facilities must ensure that properly trained personnel (and certified in CPR for Healthcare Providers) are available immediately (24 hours per day) to provide basic life support, including cardiopulmonary resuscitation (CPR), to residents requiring emergency care prior to the arrival of emergency medical personnel,
and subject to accepted professional guidelines, the resident's advance directives, and physician orders.

The American Heart Association (AHA) publishes guidelines every five years for CPR and Emergency Cardiovascular Care (ECC). These guidelines reflect global resuscitation

science and treatment recommendations. In the guidelines, AHA has established evidenced-based decision-making guidelines for initiating CPR when cardiac or respiratory arrest occurs in or out of the hospital.

The AHA urges all potential rescuers to initiate CPR unless a valid Do Not Resuscitate (DNR) order is in place; obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or initiating CPR could cause injury or peril to the rescuer.

If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services,

- in accordance with the resident's advance directives and any related physician order, such as code status, or
- in the absence of advance directives or a DNR order.

Facilities must have systems in place supported by policies and procedures to ensure there are an adequate number of staff present at all times who are properly trained and/or certified in CPR for Healthcare Providers to be able to provide CPR until emergency medical services arrives.

Additionally, facilities should have procedures in place to document a resident's choices regarding issues like CPR. Physician orders to support these choices should be obtained as soon as possible after admission, or a change in resident preference or condition, to facilitate staff in honoring resident choices. Facility policy should also address how resident preferences and physician orders related to CPR and other advance directive issues are communicated throughout the facility so that staff know immediately what action to take or not take when an emergency arises. Resident wishes expressed through a resident representative, as defined at §483.5, must also be honored, although, again physician orders should be obtained as soon as possible.

Facility staff should verify the presence of advance directives or the resident's wishes with regard to CPR, upon admission. This may be done while doing the admission assessment. If the resident's wishes are different than the admission orders, or if the admission orders do not address the resident's code status and the resident does not want to receive CPR, facility staff should immediately document the resident's wishes in the medical record and contact the physician to obtain the order.

While awaiting the physician's order to withhold CPR, facility staff should immediately document discussions with the resident or resident representative, including, as appropriate, a resident's wish to refuse CPR. At a minimum, a verbal declination of CPR by a resident, or if applicable a resident's representative, should be witnessed by two staff members, though individual States may have more specific requirements related to documenting verbal directives. While the physician's order is pending, staff should honor the documented verbal wishes of the resident or the resident's representative, regarding CPR.

Advance Directives

The right to formulate an advance directive applies to each and every resident and facilities must inform residents of their option to formulate advance directives. If a

resident has a valid Advance Directive, the facility's care must reflect the resident's wishes as expressed in their Directive, in accordance with state law. (Refer to §483.10(c)(6), F578, Residents' Right to Formulate an Advance Directive.)

NOTE: The presence of an Advance Directive does not absolve the facility from giving supportive and other pertinent care, including CPR and other basic life support that is not prohibited by the Advance Directive. The presence of a "Do Not Resuscitate" (DNR) order is not sufficient to indicate the resident is declining other appropriate treatment and services. It only indicates that the resident should not be resuscitated if respirations and/or cardiac function ceases.

Facility Policies
Facility policies should address the provision of basic life support and CPR, including:

- Directing staff to initiate CPR when cardiac or respiratory arrest occurs for residents who do not show obvious clinical signs of irreversible death and:
    - Who have requested CPR in their advance directives, or
    - Who have not formulated an advance directive or,
    - Who do not have a valid DNR order.
- Ensuring staff receive certification in performance of CPR (CPR for Healthcare Providers).

Facility policies must not limit staff to only calling 911 when cardiac or respiratory arrest occurs. Prior to the arrival of EMS, nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac or respiratory arrest in accordance with that resident's advance directives or in the absence of advance directives or a DNR order. CPR-certified staff must be available at all times to provide CPR when needed.

The presence of a facility-wide "no CPR" policy interferes with a resident's right to formulate an advance directive and should be cited at §483.10(c)(6), F578, Residents' Right to formulate an Advance Directive. Surveyors should attempt to determine if there were residents who could have been negatively affected by the facility's policy, which should be cited at §483.24(a)(3), F678.

CPR Certification
Staff must maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes *a* hands-on *session either in a physical or virtual instructor-led setting in accordance with accepted national standards.*
For concerns related to *CPR certification that meets accepted professional standards* the survey team should consider §483.21(b)(3)(ii), Services Provided by Qualified Persons, F659 and/or *§483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. F836.*

INVESTIGATIVE *PROCEDURES*:
Record Review
Ask to review the facility policies for:

- CPR
- Advance Directives and/or
- Code Status

Review facility policies to ensure:

- Staff are directed to initiate CPR when cardiac or respiratory arrest occurs for residents who do not show obvious clinical signs of irreversible death and:
    - who have requested CPR in their advance directives, or
    - who have not formulated an advance directive or,
    - who do not have a valid DNR order.
- Staff are expected to be certified in CPR for Healthcare Providers).

Review facility records verifying staff certification in CPR for Healthcare Providers

Review the resident's medical record to determine if:

- The resident has an advanced directive in place. If so:
    - Does the resident's code status reflect their wishes as recorded in their Advance Directive?
    - Does the MDS indicate that the resident has an advanced directive?
- The interdisciplinary team has reviewed the Advanced Directive on a regular basis with the resident, or representative to ensure that it is current?

Interview

Interview the resident or their representative to determine:

- If they have formulated an Advance Directive (compare resident wishes to physician's orders);
- If staff review the Advance Directive at least quarterly (with care planning) to see if it still reflects the resident's wishes.

Interview nursing staff to determine:

- How they know each resident's code status;
- Who is responsible for performing CPR;

NOTE: In addition to actual or potential physical harm, always *observe for visual cues of psychosocial distress and* consider whether psychosocial harm has occurred when determining severity level. (See *guidance on Severity and Scope Levels and* Psychosocial Outcome Severity Guide *found in the Survey Resources zip file located at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes*).

KEY ELEMENTS OF NONCOMPLIANCE:

To cite deficient practice at F678, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- Provide basic life support, including CPR to a resident who required emergency life support and/or resuscitative care; or
- Ensure availability of staff who can provide CPR.
- Have appropriate policies directing staff when to initiate basic life support;
- Ensure staff is familiar with facility policies related to CPR;
- Ensure staff knows how to confirm residents' code status in an emergency; and
- Ensure staff maintain current CPR certification for healthcare providers *in accordance with the accepted national standards.* through a CPR provider whose training includes hands-on practice and in-person skills assessment.

DEFICIENCY CATEGORIZATION

Examples of Severity Level 4 ***immediate jeopardy to resident health and safety*** **include, but are not limited to:**

- Failure to provide, or a delay in providing CPR to a resident with no advance directive, who collapsed in the dining room.
- Facility implementation of a No CPR policy resulting in psychosocial harm to residents who became distraught that they would have to relocate or have to sign a DNR.

Severity Level 3, ***actual harm that is not immediate jeopardy***
CMS believes that noncompliance related to any of the key elements listed above with an actual or potential outcome to one or more residents would result in Immediate Jeopardy, therefore no example of level 3 severity is given.

An example of Level 2, no actual harm, with potential for more than minimal harm, that is not immediate jeopardy includes, but are not limited to:
Noncompliance that results in no more than minimal physical, mental, and/or psychosocial discomfort to the resident, and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial wellbeing.

- Failure to ensure all facility staff received training in CPR for Healthcare Providers, resulting in some staff responsible for providing CPR not receiving the correct CPR training.

Severity Level 1, *no actual harm with potential for minimal harm* Severity Level 1 does not apply for this regulatory requirement because the failure of the facility to be able to provide basic life support, including CPR, by properly trained staff in accordance with facility policies, advance directives and related physician's orders creates the potential for more than minimal harm.