STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345397	A. BUILDING _____ B. WING _____	C 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORELAND HLTH CARE & RETIREME	200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted onsite 06/20/22 - 06/24/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # VOE111.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 06/20/22 - 06/24/22. Event ID # VOE111. The following intakes were investigated: NC00182852, NC00186570, NC00187270, NC00188663, NC00181781. 2 of the 10 complaint allegations were substantiated resulting in deficiencies. Past Non Compliance was identified at: CFR 483.24 at tag F678 at scope and severity (J) CFR 483.70 at tag F835 at scope and severity (J) The tag F678 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		8/5/22

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

Electronically Signed | 07/15/2022

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F 636	Continued From page 1	F 636		

assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes

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F 636	Continued From page 2 prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to 1) complete and transmit Minimum Data Set (MDS) admission assessments within the required timeframe for 2 of 9 residents (Resident #203, #1), 2) failed to complete a discharge with return anticipated assessment within the required timeframe for 1 of 9 residents (Resident #47) and 3) failed to complete a 14-day MDS assessment within the required timeframe for 1 of 9 residents reviewed for Resident Assessments (Resident #103). Findings included. 1) Resident #203 was admitted to the facility on 05/11/22. Her diagnoses included hip fracture and diabetes. A review on 06/24/22 of Resident #203's admission assessment with the ARD (assessment reference date) of 05/18/22 revealed the assessment was incomplete and was in progress. Resident #1 was admitted to the facility on 05/30/22. His diagnoses included Parkinson's and seizures.	F 636	F636 □ Comprehensive Assessment and Timing Corrective actions have been taken for all affected residents as follows: Resident #203: Assessment with ARD 05/18/22 was completed on 6/30/22 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 7/1/22 in MDS Batch #1653. Resident #1: Assessment with ARD of 06/06/22 was completed on 7/13/22 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 7/13/22 MDS Batch #1661. Resident #47: Assessment with ARD of 05/31/22 was completed on 6/28/22 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 6/29/22 in MDS Batch #1651. Resident #103: Assessment with ARD of 6/14/22 was completed on 7/14/22 by the facility Minimum Data Set nurse and was submitted into state database and acceptance is in pending at the time of this POC date of 7/15/22.	

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F 636	Continued From page 3 A review on 06/24/22 of Resident # 1's admission assessment with the ARD of 06/06/22 revealed the assessment was incomplete and was in progress. 2) Resident #47 was admitted to the facility on 10/27/20. Her diagnoses included diabetes, and epilepsy. A review on 06/24/22 of Resident # 47's discharge with return anticipated assessment with the ARD of 05/31/22 revealed the assessment was incomplete and was in progress. An interview was conducted on 06/24/22 at 10:39 AM with the MDS nurse. She stated she transitioned from the Director of Nursing to the MDS position in January 2022, and she continued helping to do other roles. She stated she had to fill in for the wound nurse during the month of May and filled in for the Staff Development Coordinator nurse and also had resident care assignments including passing medications due to short staffing. She stated the MDS assessments were behind due to staffing and having to help with other roles in the facility. An interview was conducted with the DON on 06/24/22 at 4:00 PM. She indicated she was aware the MDS assessments were behind. She stated she expected MDS assessments to be completed and transmitted within the required timeframes. An interview was conducted on 06/24/22 at 3:45 PM with the Administrator. She stated the facility was looking to hire additional staff. She acknowledged that the MDS assessments were	F 636	Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all current residents was completed in order to identify any resident with a comprehensive assessment that has not been completed within the required timeframe. The Master Minimum Data Set Scheduler in Point Click Care was utilized to perform this audit. This audit was completed on July 14_2022 by the Regional MDS, MDS Coordinator and Administrator. Audit Results 11 of 17 residents identified as having most recent comprehensive assessment completed within the required timeframe. 6 of 17 residents were identified as having a comprehensive assessment that was not completed by the required due date. Of these 6 they will be completed by 8/1/2022 Systemic Changes On 07/14/22, the Regional Minimum Data Set Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of ensuring that each resident receive a	

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F 636	Continued From page 4 behind and stated corporate was going to send someone to assist the MDS Nurse to get the assessments caught up. 3) Resident #103 was admitted to the facility on 06/07/22. A review on 06/21/22 of the MDS assessments for Resident #103 revealed a 5-day MDS was not completed by ARD due date 06/14/22, being 7-days overdue. During an interview on 06/21/22 at 4:00 PM MDS Nurse #1 stated the 5-day MDS assessment should have been completed by 06/14/22/22. The MDS Nurse indicated the reason the assessment was late was because the facility was short staffed, and she being the only MDS nurse was often pulled from her duties to work on the floor as the wound nurse or work passing medications on one of their medication carts. Nurse #1 said their corporate MDS Nurse was scheduled to help remotely one-day a week to complete all resident MDS assessments, which was not enough time, resulting in the facility having late MDS assessments. She indicated the facility was currently in the process of hiring new nurses. An interview on 06/21/22 at 4:15 PM with the Administrator and Director of Nursing (DON) stated they expected all the MDS assessments to be completed in a timely manner per the regulation.	F 636	comprehensive assessment according to the rules stated in Chapter 2 of the RAI (resident assessment instrument) Manual. OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a residents status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment, and Significant Correction to Prior Comprehensive Assessment. The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day one if: " this is the residents first time in this facility, OR " the resident has been admitted to this facility and was discharged return not anticipated, OR " the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. The ARD (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at	

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F 636	Continued From page 5	F 636	12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14). The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than. The CAA(s) completion date (item V0200B2) must be no later than day 14. The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days). The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than. The CAA(s) completion date (item V0200B2) must be no later	

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F 636	Continued From page 6	F 636	than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than. The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days). The Significant Change Status Assessment is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT□s determination was made that the resident had a significant change. The ARD must be less than or equal to 14 days after the IDT□s determination that the criteria for an SCSA are met (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 636	Continued From page 7	F 636	requirements. The Director of Nursing or designee will begin auditing the facility's compliance with ensuring that comprehensive Minimum Data Set assessments are scheduled and completed within required timeframes as stated in Chapter 2 of the RAI (resident assessment instrument) Manual using the quality assurance survey tool entitled Comprehensive Assessments and Timing Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months or until substantial compliance is achieved and maintained. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 8/5/22	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment	F 638		8/5/22

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F 638	Continued From page 8 A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14-calendar days of the Assessment Reference Date (ARD, the last day of the look-back period) for 5 of 9 residents reviewed for resident assessments (Resident #5, #6, #7, #8, and #12). Findings included: 1. Resident #5 was admitted to the facility on 07/30/21. The most recent quarterly MDS assessment for Resident #5 was reviewed. The assessment had an ARD of 02/15/22 and a completion date of 05/18/22. In an interview conducted with the MDS Nurse on 06/21/22 at 4:00 PM she stated she had not been able to complete the MDS assessments on time, because she had been frequently assigned to work as a staff nurse. She remarked she was currently the only MDS Nurse at the facility and in the past, there had been two MDS nurses to do the same amount of work. She indicated the facility was currently in the process of hiring new nurses. An interview on 06/21/22 at 4:15 PM with the Administrator and Director of Nursing (DON) stated they expected all the MDS assessments to be completed on time. 2. Resident #6 was admitted to the facility on	F 638	F638 Quarterly Assessment at Least Every 3 Months Corrective Action Minimum Data Set assessments for affected residents that were identified as not being completed within the required timeframe were completed and submitted to the state database as follows: " Resident #5: MDS with Assessment Reference Date of 02/15/22 was completed on 05/18/22 (our records show 3/11/22) and was submitted and accepted into state database on 3/14/22 in MDS Batch #1598 " Resident #6: MDS with Assessment Reference Date of 02/15/22 was completed on 05/18/22 (our records indicate 3/11/22) and was submitted and accepted into state database on 3/14/22 in MDS Batch #1598. " Resident #7: MDS with Assessment Reference Date of 02/15/22 was completed on 05/18/22 (our records show 3/14/22) and was submitted and accepted into state database on 3/15/22 in MDS Batch # 1599. " Resident #8: MDS with Assessment Reference Date of 02/16/22 was completed on 05/19/22 (completed on 3/14/22 in our records and was submitted and accepted into state database on 3/15/22 in MDS Batch #1599. " Resident #12: MDS with Assessment	

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F 638	Continued From page 9 10/08/20. The most recent quarterly MDS assessment for Resident #6 was reviewed. The assessment had an ARD of 02/15/22 and a completion date of 05/18/22. In an interview conducted with the MDS Nurse on 06/21/22 at 4:00 PM she stated she had not been able to complete the MDS assessments on time, because she had been frequently assigned to work as a staff nurse. She remarked she was currently the only MDS Nurse at the facility and in the past, there had been two MDS nurses to do the same amount of work. She indicated the facility was currently in the process of hiring new nurses. An interview on 06/21/22 at 4:15 PM with the Administrator and Director of Nursing (DON) stated they expected all the MDS assessments to be completed on time. 3. Resident #7 was admitted to the facility on 11/15/21. The most recent quarterly MDS assessment for Resident #7 was reviewed. The assessment had an ARD of 02/15/22 and a completion date of 05/18/22. In an interview conducted with the MDS Nurse on 06/21/22 at 4:00 PM she stated she had not been able to complete the MDS assessments on time, because she had been frequently assigned to work as a staff nurse. She remarked she was currently the only MDS Nurse at the facility and in the past, there had been two MDS nurses to do the same amount of work. She indicated the facility was currently in the process of hiring new nurses. An interview on 06/21/22 at 4:15 PM with the	F 638	Reference Date of 03/02/22 was completed on 06/02/22 (3/23/22- our records indicate) and was submitted and accepted into state database on 3/24/22 in MDS Batch #1606. Identification of other residents who have the potential to be affected by this alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 7/14/22, the MDS Coordinator and Administrator conducted a 100% audit on all current residents in order to determine if they have had a Minimum Data Set Assessment completed at least once every 3 months with the Assessment Reference Date not being greater than 92 days since prior assessment's reference date – AND - to determine if the current in progress assessment (ARD 7/14/22 or earlier) or the last completed assessment was completed by the required due date. The results of this audit were: • 19_of_63_current residents were identified as having been admitted to the facility less than 90 days ago and have not come due for a quarterly Minimum Data Set assessment yet. • 44 of 44 eligible residents identified as having a Minimum Data Set assessment completed that met the requirement of the Assessment Reference Date not being greater than 92 days since prior assessment's reference date.	

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F 638	Continued From page 10	F 638		

Administrator and Director of Nursing (DON) stated they expected all the MDS assessments to be completed on time.

4. Resident #8 was admitted to the facility on 10/19/20. The most recent quarterly MDS assessment for Resident #8 was reviewed. The assessment had an ARD of 02/16/22 and a completion date of 05/19/22.

In an interview conducted with the MDS Nurse on 06/21/22 at 4:00 PM she stated she had not been able to complete the MDS assessments on time, because she had been frequently assigned to work as a staff nurse. She remarked she was currently the only MDS Nurse at the facility and in the past, there had been two MDS nurses to do the same amount of work. She indicated the facility was currently in the process of hiring new nurses.

An interview on 06/21/22 at 4:15 PM with the Administrator and Director of Nursing (DON) stated they expected all the MDS assessments to be completed on time.

5. Resident #12 was admitted to the facility on 09/09/20. The most recent quarterly MDS assessment for Resident #12 was reviewed. The assessment had an ARD of 03/02/22 and a completion date 06/02/22.

In an interview conducted with the MDS Nurse on 06/21/22 at 4:00 PM she stated she had not been able to complete the MDS assessments on time, because she had been frequently assigned to work as a staff nurse. She remarked she was currently the only MDS Nurse at the facility and in the past, there had been two MDS nurses to do

- 2 of 44 eligible residents identified as having their most recent Minimum Data Set assessment completed by the required due date.

- 31 of 44 eligible residents identified as having their most recent Minimum Data Set that was not completed by the required due date.

- 11 of 44 eligible residents were identified as having a current Minimum Data Set assessment that is currently in progress and not due to be completed at the time of this audit.

Systemic Changes

On 07/14/22, the Minimum Data Set Nurse Consultant conducted in-service training for the facility Minimum Data Set Nurse(s) on the importance of scheduling and completing a Minimum Data Set assessment for all residents at least once every 3 months per chapter 2 of the Resident Assessment Instrument manual. The education emphasized that all residents must have no more than 92 days between Assessment Reference Dates of each Minimum Data Set assessment (Admission, Annual, Quarterly, Significant Change). Focus was also placed on the importance of

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F 638	Continued From page 11 the same amount of work. She indicated the facility was currently in the process of hiring new nurses. An interview on 06/21/22 at 4:15 PM with the Administrator and Director of Nursing (DON) stated they expected all the MDS assessments to be completed on time.	F 638	ensuring that all Minimum Data Set assessments be completed, encoded and transmitted within the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument Manual. Monitoring The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance within the regulatory requirements; The Director of Nursing and/or designee will review 5 random (current) residents who have been in the facility for at least 6 months to validate whether or not they have had an Minimum Data Set assessment completed at least once every 3 months per the Resident Assessment Manual, including whether or not the assessment was completed within the required timeframe. This will be completed using the Quality Assurance tool entitled Quarterly Completion of Minimum Data Set Assessments. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator	

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F 638	Continued From page 12	F 638	The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 8/5/22	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §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. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and Nurse Practioner interview, the facility failed to perform cardiopulmonary resuscitation (CPR) while waiting for Emergency Medical Services (EMS) to arrive for 1 of 1 resident reviewed for CPR (Resident #205) who was observed by Nurse #7 to have no pulse and determined to have a full code status. Resident #205 was provided CPR by EMS and transported via EMS to the hospital where she was intubated and admitted to the intensive care unit. Findings included: A Cardiopulmonary Resuscitation (CPR) policy written October 2001 and revised in April 2018 stated, in part, it was the policy of this nursing facility to act affirmatively to preserve the life of all residents. It is the policy of this facility to initiate Basic Life Support CPR as defined by the American Heart Association or the American Red Cross. This will be done by trained staff that have	F 678	Past noncompliance: no plan of correction required.	

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completed either of the above-mentioned courses and have a current certification.

The policy stated the purpose of CPR was to ventilate and establish circulation on a resident with absence of respirations and pulse once resident was assessed: 1) if a resident was noted with a significant change of condition, the staff member should immediately alert the nurse for the resident and a code blue called over the intercom, 2) all nurses and staff should respond to the room and the crash cart taken to the room, 3) the staff nurse responsible for resident begins an assessment of the resident, applied the (Automated external defibrillators (AED), and implements CPR if the resident was a full code status. Another staff member should be verifying the code status by reviewing the physician orders for the resident, 4) another staff member should call physician, prepare paperwork for transfer and call family, and 5) staff should follow the basic life support procedures based on their most recent training.

Resident #205 was admitted to the facility on 02/02/22 with diagnoses to include, in part, acute respiratory failure with hypoxia, pneumonia, failure to thrive, and history of lung cancer with a lung resection in 2018.

A physician ' s order written on 02/02/22 indicated Resident #205 was a full code.

The Minimum Data Set 5-day assessment dated 02/07/22 revealed the resident was severely cognitively impaired.

A nursing progress note written 02/27/22 by Nurse #7 revealed "called to resident room by

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Nursing Aide {Medication Aide #2 working as Nurse Aide}. Upon entering room resident has thick white milky mucus running from her mouth, there was no rise or fall of chest movement and no pulse detected. Nurse went to nurses ' station to see if resident was a Do Not Resuscitate (DNR) or a full code and called Emergency Medical Services (EMS). EMS arrived at 5:31 AM; out of facility with resident at 5:35 AM with CPR in progress. Responsible Party (RP) was notified. Reported to Emergency Room (ER) nurse at hospital."

A written statement dated 02/27/22 from Nurse #7 revealed, in part, "Nurse stated she worked with the resident on 02/26/22 from 7:00 PM to 7:00 AM. Nurse stated the Medication Aide (MA) called for her to come to the resident ' s room and stated she was not breathing. Nurse assessed resident and noted no pulse. Nurse then went to the nurse ' s station to check code status and saw that resident was a full code. Nurse stated she proceeded to call 911 and get paperwork ready for EMS. Nurse then proceeded back to the resident ' s room and then heard the phone ringing and believed it to be EMS calling for door code. She gave the code to EMS to enter the building. Nurse stated (in retrospect) minutes went by so quickly that she felt EMS was there before she could initiate CPR."

A review of the EMS Report on 02/27/22 revealed the call was received at 5:26 AM, dispatched at 5:27 AM, EMS was enroute at 5:28 AM, at resident at 5:31 AM, left facility at 5:43 AM and arrived at hospital at 5:47 AM. Upon arrival to facility, Resident was laying supine (on back) in bed. Carotid and radial pulse were absent. The EMS report indicated nursing staff had reported

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that the resident was an expected death, nursing staff also stated the resident was a full code and CPR was not started. The note indicated the resident was warm to touch and CPR was started and continued by EMS and monitored and transported to the hospital by EMS without incident.

A review of the hospital Emergency Room (ER) record on 02/27/22 revealed, in part, resident arrived at 5:53 AM on 02/27/22 via EMS with CPR in progress. The ER note indicated Resident had no spontaneous breathing, unresponsive and was intubated. Vital signs were recorded as Heart Rate (HR) 136, Respiration Rate (RR) 29, Blood Pressure (BP) 58/40, 02 saturation 95% on ventilator and she was warm to touch.

An interview with Nurse #7 via phone on 06/21/22 at 2:12 PM revealed on the morning of 02/27/22 Med Aide #2 who was working as a Nurse Aide came to her and told her Resident #205 had a white foam coming out of her mouth. She stated she assessed Resident #205 and she had no pulse, was warm and grey and non-responsive. She went to the nurse ' s station to see what the resident ' s code status was, saw that she was a full code and called 911. Nurse #7 stated while she was on the phone with EMS, she was getting the paperwork printed and then went to Resident #205 ' s room. Nurse #7 stated the phone rang and she thought it was EMS calling so she left the room to answer the call and give EMS the code to enter the building. Nurse #7 reported she did not recall telling Med Aide #2 to perform CPR. Nurse #7 stated it seemed like only minutes went by before EMS appeared and she walked them down to the resident ' s room after letting them in.

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She stated when they entered Resident #205 ' s room, MA 2 was in the room with the resident, but she was not performing CPR and EMS determined the resident had no pulse and started CPR. Nurse #7 stated EMS was transporting the resident out of the facility while performing CPR and she learned later the resident was intubated and admitted to the intensive care unit (ICU). During the interview with Nurse #7, she stated "in looking back, I should have started CPR on the resident."

An interview with the Administrator on 06/22/22 at 8:55 AM revealed EMS was located behind the facility on the same street and was about 3 minutes away. The Administrator stated Nurse #7 was following the protocol when she went to the nurses ' station to confirm the resident ' s code status and called EMS. The Administrator stated in hindsight she did not know what the nurse was thinking because she should have directed the Med Aide to let EMS in the building while she performed CPR. The Administrator agreed 9 minutes (5:26 AM - 5:35 AM) was a long time to wait for CPR to be initiated.

An interview with the Director of Nursing (DON) on 06/22/22 at 9:30 AM. The DON stated if a resident became unresponsive in the facility, the nurse would be required and expected to assess the resident, confirm their code status and if applicable (full code), to begin or direct the initiation of CPR

An interview was conducted with Medication Aide #2 on 06/23/22 at 4:46 AM. MA #2 reported she was assigned to Resident #205 on the night of 02/27/22 and this had been the first time she worked with this resident. She stated when she

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did her first round of care around 12:00 AM she checked on Resident #205 to see if she needed to be changed. MA #2 stated the head of her bed was elevated and she was not incontinent. The MA stated Resident #205 did not verbally speak to her while she was doing her rounds. MA #2 stated she checked on the resident at around 2:00 AM and she was not incontinent. MA #2 stated she seemed about the same and noted no new changes at that time. MA #2 stated at about 5:20 AM she went in to check on Resident #205 and she was incontinent. The MA stated she was "gurgling" and seemed to be congested, so she left the head of the bed elevated while turning the resident to her side to change her. She stated when she rolled the resident back toward her the "gurgling" had stopped, and she had white foam coming from her mouth. MA #2 stated the resident was pale and warm to the touch. MA #2 reported she called for Nurse #7 immediately. The nurse assessed the resident and stated she would call 911. The MA reported Nurse #7 called 911 and EMS arrived at the facility quickly because they were located just around the corner. The MA reported she was not instructed to perform CPR on Resident #205, but she remained with the resident until EMS arrived. The MA reported Nurse #7 did not call a "code blue" (cardiac arrest) to initiate CPR.

An interview was conducted with Med Aide #1 on 06/23/22 at 2:30 PM. MA #1 reported she came in earlier than usual on the morning of 02/27/22 and when she arrived Nurse #7 was sitting at the nurse ' s station. MA #1 reported Nurse #7 informed her that Resident #205 had passed away and she was waiting for EMS to arrive. She stated about 5:30 AM, EMS arrived, and Nurse #7 walked with EMS to the resident ' s room. MA

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#1 stated she saw EMS leaving the facility performing CPR on Resident #205 while enroute to the hospital.

An interview was conducted with the Nurse Practioner (NP) on 06/23/22 via phone at 3:25 PM. The NP stated she would have expected Nurse #7 to call a code blue and initiate CPR once learning she was a full code and EMS had been notified. The NP stated every minute counts when a resident was not breathing, and CPR should be initiated as soon as possible.

F678

The corrective action for noncompliance completed 03/11/22 was as follows:

· For the resident affected by the deficient practice.

Resident #205 experienced a change in condition on 2/27/2022 at approximately 5:20 AM, resident noted to stop breathing while care was being provided by Medication Aide #2. Medication Aide #2 immediately notified Nurse #7 of the change in condition. At approximately 5:23 AM Nurse #7 entered the room and performed an assessment of the resident and could not detect a carotid pulse or respirations. She left the room to check code status and call Emergency Medical Services. Resident ' s code status was Full Code. At approximately 5:28 AM, Nurse #7 returned to the room and exited shortly after due to Emergency Medical Services calling for the code to the door. Cardiopulmonary resuscitation (CPR) was not performed by facility staff. At approximately 5:31 AM, Emergency Medical Services entered the room and initiated CPR. At

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approximately 5:35 AM, Emergency Medical Services left the facility with the resident to transfer to the hospital for emergency care. Nurse #7 notified the responsible party on 02/27/2022.

Root Cause Analysis completed 3/2/2022

Upon observation of Resident #205 with absence of respirations, fixed pupils, unresponsive, no carotid pulse, and grey pallor, Nurse #7 proceeded to the nurse ' s station to verify code status and then immediately activated Emergency Medical Services to ensure rapid response to the facility. Through investigation of the event, including interviews with staff on duty at the time, interview with the previous nurse and staff on duty the shift prior, review of the employee ' s work records, and the actions initiated by the nurse, the facility did not feel Nurse #7 intentionally withheld a prudent service, but rather was focused on activating emergency services to be enroute, code status validation, and family awareness. Per facility protocol, Nurse #7 should have called a code blue (Cardiac or respiratory arrest) when the resident was noted with a change in condition and started CPR once code status was verified.

As an additional measure, the Administrator and Director of Nursing utilized the North Carolina Board of Nursing Complaint Evaluation Tool on 03/01/2022. This resulted in a recommendation for a Board of Nursing consultation. A call was placed to the North Carolina Board of Nursing on 03/02/2022. On 03/04/2022 the North Carolina Board of Nursing was consulted. The incident was submitted for board review on 03/02/2022.

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· Identification of potentially affected residents and corrective actions taken.

All current residents experiencing a change in condition are at risk to be affected.

On 03/01/2022 all current residents were assessed by a licensed nurse under the direction of the Director of Nursing (DON) for a change in condition. This was completed by obtaining current vital signs, oxygen saturation, and lung sounds were assessed.
No new changes in condition were identified.

This was completed and reviewed by the Director of Nursing on 03/01/2022.

On 03/01/2022, the Director of Nursing audited 100% of current licensed staff to ensure valid CPR certifications. A 100% audit was conducted, which included all full time, part-time, ' as needed," and contracted nurses. The results yielded 2 facility employed licensed nurses with expired CPR certifications.

Any licensed nurse found without active CPR certification was scheduled for a CPR class March 7th or March 11th, 2022.

Completed: 03/11/2022

By Whom: Regional Staff Development Coordinator

· Systemic Changes

Review of facility system to track CPR certifications reviewed by Director of Nursing on 03/01/2022. No current system was in place.

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On 03/01/2022, a system for tracking CPR certifications for licensed nurses was initiated by the Director of Nursing. Director of Nursing and/or Staff Development Coordinator (or designee) will log each licensed nurse who has active CPR certification, and date of expiration into the electronic scheduling system. The electronic scheduling system will not allow the staff member to be scheduled for a working shift if the CPR certification expired. Agency Nurses will be tracked by this same electronic system when agency nurses are utilized.

On 03/01/2022 training was initiated by the Director of Nursing and Nurse Management staff for all full time, part time, and ' as needed ' Nurses, Medication Aides, Certified Nursing Assistants, and agency staff:

Topics included:
· Change in condition policy
· Code status education

Required CPR disciplines, i.e., Licensed Nursing Staff

On 03/01/2022 all full time, part time, and ' as needed ' Nurses, including agency nurses, were educated by the Director of Nursing and/or Nurse Management staff.

Topics included:
· Cardiopulmonary Resuscitation policy? Initiating Cardiopulmonary Resuscitation timely.
· Education included notification of Nursing Administration and Administrator when nursing concerns arise, assistance was needed, personal illness, or staffing issues arise.

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On 03/01/2022 training was initiated for the Administrator and the Director of Nursing by the Corporate Clinical Services Consultant.

Topic included:

System for tracking CPR certifications for licensed nurses and/or agency licensed nurses. Director of Nursing and/or Staff Development Coordinator (or designee) will log each licensed nurse who has an active CPR certification with date of expiration into the electronic scheduling system. The electronic scheduling system will not allow the staff member to be scheduled for a working shift if the CPR certification expired.

This training was incorporated into the general orientation program and will be discussed during all general orientation programs that are completed for identified staff. The identified staff who have not received this education by 03/03/2022 will not be allowed to work until the education has been received.

This system was immediately implemented by the Director of Nursing on 03/01/2022.

A CPR class was scheduled for 03/07/2022 and 3/11/2022 at the facility and was taught by a cardiopulmonary resuscitation instructor.

100% of licensed nurses validated by Director of Nursing as CPR certified on 03/11/2022.

All newly hired licensed nurses including agency nurses will present an active CPR certification upon hire or upon facility assignment. This will be validated by the Staff Development Coordinator and/or the Director of Nursing in her absence; all

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newly hired licensed nurses and agency nurses upon assignment, evidence of CPR certification will be entered in the electronic scheduling system for tracking purposes effective March 01, 2022.

Completed: 03/11/2022 and validated by the Director of Nursing.

Monitored monthly by the Director of Nursing.

Director of Nursing initiated mock CPR drills on 03/03/2022 to monitor and ensure licensed nurse preparedness in the event of resident code blue. The Director of Nursing is monitoring mock CPR drills to provide feedback to the facility Quality Assurance Committee in order to adjust education as needed to meet the needs and opportunities of the licensed team. Mock drills have been scheduled to include day shift and night shift (12 hour shifts for licensed nurses) and have included any designated weekend staff.

Mock drills will continue indefinitely on a quarterly basis to include all shifts and weekend only staff. This will be completed under the direction of the Director of Nursing. The mock drills will specifically monitor for timely initiation of CPR. The Quality Assurance (QA) committee will monitor the results of the mock drills quarterly and make education modifications as necessary based on the findings.

· Quality Assurance Plan

The Director of Nursing or designee will monitor compliance with change in condition by using the QA tool "Change in condition." Changes in condition will be identified in the facility ' s clinical

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review process weekly reviewing progress notes for changes in condition. Beginning on 03/07/2022, this will be completed weekly for 8 weeks then monthly x 2 months. The QA tool will audit a sample of residents for changes in condition and staff response, Physician, and responsible party notification. In addition, mock codes will be completed once on day shift, once on evening shift, and once on night shift then quarterly. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting.

The Administrator or designee will monitor compliance with CPR certification using the QA tool "CPR Certification." This will begin 03/08/2022 and will be completed weekly for 4 weeks then monthly times 2 months. The QA tool will audit to ensure CPR certifications are being tracked in the electronic system and that all nurses are currently CPR certified. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate.

Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting.

The Quality Assurance Committee members are as follows:

Medical Director
Administrator
Director of Nursing
Admissions Marketing

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F 678	Continued From page 25 Dietary Manager Maintenance Director Social Services Activities Director Business Office Manager Minimum Data Set Nurse Completion Date: 3/11/2022 As part of the validation process on 06/23 through 06/24/22, the plan of correction was reviewed and included a sample of staff which included nurses, medication aides, and nurse aides who were interviewed regarding in services they received related to the deficient practice. All staff interviews stated they had been in serviced regarding the change in condition policy and the CPR policy. Staff stated they were in serviced verbally and in person by the Director of Nursing and provided the policies regarding change of condition and when to call a code blue with cardiac arrest and initiate CPR. Staff stated they were required to participate in mock code blue drills to ensure they were following the CPR policy and procedures. A review of all the documents provided to correct the deficient practice was completed. All facility policy and procedures that were provided to address the deficient practice were reviewed. The facility alleges full compliance with this plan of correction effective 03/11/2022.	F 678		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725		7/29/22

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F 725	Continued From page 26 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide sufficient staff resulting in the Minimum Data Set (MDS) nurse having to perform other duties to include wound care treatments and resident care assignments which resulted in failure to complete and transmit timely MDS assessments for 9 of 9 residents (#203, #1, #47, #5, #6, #7, #8, #12, #103) whose MDS assessments were reviewed. Findings included. This tag is cross referenced to F636-E and	F 725	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 725	

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F 725	Continued From page 27 F638-E. Based on record review and staff interviews the facility failed to 1) complete and transmit MDS admission assessments within the required timeframe for 2 of 9 residents (Resident #203, #1), 2) failed to complete a discharge with return anticipated assessment within the required timeframe for 1 of 9 residents (Resident #47) and 3) failed to complete a 14-day MDS assessment within the required timeframe for 1 of 9 residents reviewed for Resident Assessments (Resident #103). Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14-calendar days of the Assessment Reference Date (ARD, the last day of the look-back period) for 5 of 9 residents reviewed for resident assessments (Resident #5, #6, #7, #8, and #12). An interview was conducted on 06/24/22 at 10:39 AM with the MDS Nurse. She stated she transitioned from the Director of Nursing to the MDS position in January 2022, and she continued helping to do other roles. She stated she had to fill in for the wound nurse during the month of May and filled in for the Staff Development Coordinator and also had resident care assignments including passing medications due to short staffing. She stated the MDS assessments were behind due to staffing and having to help with other roles in the facility. An interview was conducted on 06/24/22 at 3:45 PM with the Administrator. She stated the facility was looking to hire additional staff. She acknowledged that the MDS assessments were	F 725	Corrective Action for Affected Residents On July 12th , the Administrator and Director of Nursing provided additional education to the Nursing Scheduler on the need to ensure adequate staffing of Registered/Licensed Practical nurses, Medication Nurses, and Wound nurse to prevent the pulling of the Minimal Data Set (MDS) nurse to a staffing assignment. Corrective Action for Potentially Affected Residents On July 11th the Director of Nursing reviewed the nursing schedule for the upcoming four (4) weeks to ensure adequate hall coverage with, licensed practical nurse, medication aide, and wound nurse was scheduled for each day as indicated without having to pull the MDS nurse into the role. Compliance was noted. Systemic Changes The Director of Nursing will review the monthly staffing schedule two times per week to ensure hall coverage and wound care coverage to ensure an RN and/or LPN as well as a Medication Aide is scheduled for these roles as indicated without having to pull the MDS nurse to those positions. On July 7th , The Administrator, Director of Nursing and Director of Operations reviewed the facilities current recruitment plan for Registered Nurses and Licensed Practical Nurses. As a result, the current recruitment efforts will continue: • On July 8th advertisements were refreshed with Indeed (staff recruiting agency) for vacant nursing staff positions that included Registered Nurses and	

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F 725	Continued From page 28 behind and stated corporate was going to send someone to assist the MDS Nurse to get the assessments caught up. She stated it was difficult to retain staff.	F 725	Licensed Practical Nurses. The Registered Nurse advertisements were refreshed and updated on July 8th The advertisements were placed by the Administrator. • The facility has staffing agreements with staffing agencies to provide a variety of personnel on an as needed basis Contracts were signed with Maxim, MAS, Freedom Staffing, and Global Staffing agencies. • The facility has an approved New Hire Bonus for RNs and LPNs with substantial retention/New Hire bonus paid out over 24 months. The facility also has a lucrative employee referral bonus. • MDS will be audited for timely completion of assessments by the administrator or designee. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. The following new measures will be implemented to enhance the facility recruitment efforts of RN and LPNs. • Administrator or designee will contact the North Carolina Board of Nursing to obtain a list of Registered Nurses with addresses in Columbus, Brunswick, Bladenboro counties and A direct mail recruitment/email blast/on site job fair/Virtual Job Fair for employment will be mailed directly to all those registered nurses and licensed practical nurses listed. Completion Date to be scheduled 7/29/22	

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F 725	Continued From page 29	F 725	• The Director of Nursing and/or designee will communicate with appropriate leaders and/or instructors of local community colleges to enhance recruitment of RNs and LPNs by 7/29/22. Education On July 15th the Administrator and Director of Nursing educated all Registered Nurses, Licensed Practical Nurses, and Medication Aides via an person in-service and/or written memorandum of the procedure change for calling out. The procedure change outlines that any Registered Nurse, Licensed Practical Nurse, or Medication Aide who cannot work their assigned shift must notify the RN on call directly. The RN on call will notify Director of Nursing or the Administrator in her absence immediately. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Licensed Nurses and Medication Aides, and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Staff that have not received the education by July 29, 2022 will not be allowed to work until it has been completed. Quality Assurance The Administrator or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Staffing. Additionally, MDS will be audited for timely completion of assessments. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved	

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F 725	Continued From page 30	F 725	by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance 7/29/22	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		8/5/22

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F 761	Continued From page 31 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility 1) failed to remove expired medications from 2 of 3 medication carts (100 hall and 200 hall medication carts), 2) failed to record an opened date for a narcotic located in the locked box in 1 of 1 medication refrigerators and 3) failed to secure medications stored on top of 1 of 3 unattended medication carts. (Medication storage cart 300 Hall) Findings included: 1) An observation was conducted on 06/20/22 at 12:20 PM along with Nurse #1 of the 100 hall and 200 hall medications carts. The following expired medications were observed: Geri Tussin (Guaifenesin- an expectorant used to treat cough and colds) with a manufacturer's expiration date of 05/22/22. GI (gastrointestinal) cocktail (liquid antacid) with an expiration date of 06/10/22. An opened Advair discus dated 05/10/22 with manufacturer's instructions to discard 30 days after removal from its foiled pouch. 2) An observation was conducted on 06/20/22 at 12:30 PM along with Nurse #1 of the medication storage refrigerator. The locked narcotic box was observed in the refrigerator with Lorazepam liquid in the locked box that was opened with no opened date recorded with the label stating the medication would expire 90 days after opening. An interview was conducted on 06/20/22 at 12:30	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 761 Corrective Action for Affected Residents The DON upon notification of alleged deficient practices of 1 and 2 immediately removed any out of date/not dated medication. The DON educated -when notified- of the unsecured mediation on top of the medication cart to LPN in charge of cart. All residents have the potential to be affected by this alleged deficient practice. Systemic Changes 1. Clinical staff that have the responsibility of Proper medication Storage to include: removal of expired medications, dating opened medication/narcotics will be assigned at shift change to ensure that there is no expired medication on cart/and that any	

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F 761	Continued From page 32 PM with Nurse #1. She stated she was the Unit Manager and the nurses checked for expired medications at least once weekly. She stated the expired medications should have been removed from the medication carts and stated the nurse should have recorded an opened date on the Lorazepam liquid and discarded it after 90 days. An interview was conducted on 06/24/22 at 4:07 PM with the Director of Nursing. She stated she expected expired medications to be removed from the medication carts, and medications should be dated when opened. She stated the nurse should check the carts when taking over the keys to the cart. 3) An observation of an unattended medication cart on the 300 Hall on 06/22/22 at 4:30 PM revealed there were 3 medication cups each containing loose pills stacked upon each other. During the observation, one resident passed the unsecured medications located on top of the medication cart. The resident was in a wheelchair and propelled herself pass the medication cart. The resident did not notice the medications on top of the cart and the medications were out of her reach. Nurse #6 was not in view of the medication cart. An interview with Nurse #6 on 06/22/22 at 4:36 PM revealed she had dispensed the medication to be administered for another Resident and separated his medications into 3 cups per his choice. Nurse #6 stated she did not mean to leave them unattended on the medication cart. She stated she had gone into another room to	F 761	opened medication/narcotics are dated. The Central Supply employee will monitor all medication that is placed in the medication room weekly during stocking. All clinical staff that have the responsibility for safe storage of medication during medication pass will be monitored during leadership rounds. This will be added to the leadership rounding sheet. 2. The DON or designee will audit removal of expired medication and the dating of open medication/narcotics weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. The DON or designee will monitor for proper security/safety of medication during med pass daily for 4 weeks and then weekly for 2 months or until resolved by Quality of Life/Quality Assurance Committee. Education All clinical staff that have responsibility for medication storage and medication safety during a medication pass will have the following education: Proper medication Storage to include: removal of expired medications, dating opened medication/narcotics and security/safety of medication during med pass. New hires will complete this education upon orientation. Clinical Staff will not be allowed to work until the Individual has completed the education. The education will be completed by 7/15/22. Central Supply will be educated on weekly checks of expired medication when stocking the medication room to be	

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F 761	Continued From page 33 assist another resident and accidently left the medication on the medication storage cart. Nurse #6 stated she should not have left the medications unsecured because anyone passing by could take them including a resident. An interview was conducted with the Director of Nursing on 06/24/22 at 4:17 PM. The DON reported she expected all the nursing staff who were on a medication cart to secure all medications for the safety of the residents.	F 761	completed by 7/15/2022. Leadership team will be educated on Quality of Life rounds in regards to the addition of safety of medication storage during med pass. Education to be completed by 7/15/22. Quality Assurance The Administrator or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Medication Storage/Medication Date/Safe storage of medication during medication pass tool. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 8/5/22	
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 835		

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F 835	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on record review and a staff interviews, the facility failed to provide oversight and leadership to ensure effective systems were implemented for staff to provide the necessary care and services by following the policy and procedure to call a code blue for a resident in cardiac arrest, to initiate Cardiopulmonary Resuscitation (CPR), to verify employed staff were current with their CPR certifications and failed to verify nurses who were present in the facility had a current CPR certification for 1 of 1 residents (Resident #205) reviewed for CPR. Findings included: This tag is cross referenced to F678 Based on record review, staff interview and Nurse Practioner interview, the facility failed to perform cardiopulmonary resuscitation (CPR) while waiting for Emergency Medical Services (EMS) to arrive for 1 of 1 resident reviewed for CPR (Resident #205) who was observed by Nurse #7 to have no pulse and determined to have a full code status. Resident #205 was provided CPR by EMS and transported via EMS to the hospital where she was intubated and admitted to the intensive care unit. A Cardiopulmonary Resuscitation (CPR) policy written October 2001 and revised in April 2018 stated, in part, it was the policy of this nursing facility to act affirmatively to preserve the life of all residents. It is the policy of this facility to initiate Basic Life Support CPR as defined by the American Heart Association or the American Red Cross. This will be done by trained staff that have	F 835	Past noncompliance: no plan of correction required.	

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completed either of the above-mentioned courses and have a current certification.

The policy stated the purpose of CPR was to ventilate and establish circulation on a resident with absence of respirations and pulse once resident was assessed: 1) if a resident was noted with a significant change of condition, the staff member should immediately alert the nurse for the resident and a code blue called over the intercom, 2) all nurses and staff should respond to the room and the crash cart taken to the room, 3) the staff nurse responsible for resident begins an assessment of the resident, applies the (Automated external defibrillator (AED), and implements CPR if the resident was a full code status. Another staff member should be verifying the code status by reviewing the physician orders for the resident, 4) another staff member should call physician, prepare paperwork for transfer and call family, and 5) staff should follow the basic life support procedures based on their most recent training.

An interview with Nurse #7 via phone on 06/21/22 at 2:12 PM revealed she never called a code blue to alert staff to respond to Resident #205. Nurse #7 stated it seemed like only minutes went by before EMS appeared and she walked them down to the resident ' s room after letting them in. She stated when they entered Resident #205 ' s room, Medication Aide (MA) #2 was in the room with the resident, but she was not performing CPR and EMS determined the resident had no pulse and started CPR. During the interview with Nurse #7, she stated "in looking back, I should have started CPR on the resident." Nurse #7 could not recall when her CPR certification expired, and she was aware she was working

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without a current certification. She stated she worked at the facility again on 02/27-night shift into 02/28/22 before getting recertified for CPR on 03/07/22. Nurse #7 stated the facility never asked her for a copy of her certification so they would not have it on file.

An interview with the Administrator on 06/22/22 at 8:55 AM revealed Nurse #7 was following the protocol when she went to the nurses ' station to confirm the resident ' s code status and called EMS. The Administrator stated only nurses were required to be CPR certified. The Administrator stated the facility should be verifying credentials and CPR certifications for the nurses. The process that should have been in place would have been to verify the CPR certification for all nurses with a copy of the CPR card in the employees ' file before orientation. The Administrator stated this was the process, "but it fell through the cracks." The Administrator stated she was not aware that Nurse #7 ' s CPR certification had expired.

An interview with the Director of Nursing (DON) on 06/22/22 at 9:30 AM revealed that only nurses were required to be CPR certified, but nurse aids and medication aides were encouraged to become CPR certified. The DON stated she had no knowledge Nurse #7 was not CPR certified while she was working here and added that being the only nurse in the building on night shift she would expect her to be CPR certified. The DON stated prior to the event on 02/27/22 with Resident #205, the DON did not have a tracking system in place to verify CPR certifications or to monitor when CPR certifications were going to expire.

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The corrective action for noncompliance completed 03/11/22 was as follows:

F835:

· For the resident affected by the deficient practice.

All residents are at risk to be affected by the deficient practice.

On 03/01/2022 a 100% audit was completed by the Director of Nursing of 100% current licensed nursing staff and current agency nurses to ensure all with current/valid Cardiopulmonary resuscitation (CPR) certifications. It was identified that 2 of the 6 licensed staff did not have current CPR certifications. The 100% audit, conducted by the Director of Nursing, included all contract/agency licensed nursing staff who were working in the facility on 03/01/2022.

Root Cause Analysis

On 03/01/2022 a root cause analysis was conducted by the Administrator, Director of Nursing, and Clinical Services Consultant and determined that there was not a system in place to track staff CPR certifications related to a new Director of Nursing was installed 1/6/2022 and did not receive education on tracking cardiopulmonary certifications.

· Identification of potentially affected residents and corrective actions taken.

All current residents experiencing a change in condition are at risk to be affected.
On 03/03/2022 the Clinical Services Consultant audited 100% current licensed nursing staff and

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current agency nurses to ensure all with current/valid CPR certifications. It was identified that 2 of the 6 licensed staff did not have current CPR certifications.

Any licensed nurse found without active CPR certification was scheduled for a CPR class March 7th or March 11th, 2022.

Completed: 3/11/2022

By Whom: Regional Staff Development Coordinator

· Systemic Changes

Review of facility system to track CPR certifications reviewed by Director of Nursing on 03/01/2022. No current system was in place.

On 03/01/2022 the Licensed Administrator and Director of Nursing were educated by the Corporate Clinical Services Consultant regarding the CPR policy, initiating timely CPR, and ensuring all licensed nursing staff who work have current/valid CPR Certifications. The education included required monitoring of CPR Systems to ensure compliance.

The licensed Administrator and the Director of Nursing Services voiced understanding. The education was delivered in person, via policy provided, review of policy, and review of required system implementation for tracking and ensuring compliance with policy.

Time was allowed for feedback and question/answering session.

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F 835	Continued From page 39 Completed: 03/01/2022 By Whom: Corporate Clinical Services Consultant This training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed for identified staff. The identified staff who have not received this education by 03/03/2022 will not be allowed to work until the education has been received. On 03/01/2022, a system for tracking CPR certifications for licensed nurses was initiated by the Director of Nursing. Director of Nursing and/or Staff Development Coordinator (or designee) will log each licensed nurse who has active CPR certification, and date of expiration into the electronic scheduling system. The electronic scheduling system will not allow the staff member to be scheduled for a working shift if the CPR certification was expired. Agency Nurses will be tracked by this same electronic system when agency nurses are utilized. The Quality Assurance Committee members are as follows: Medical Director Administrator Director of Nursing Admissions Marketing Dietary Manager Maintenance Director Social Services Activities Director Business Office Manager Minimum Data Set Nurse	F 835		

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F 835	Continued From page 40	F 835		

The Clinical Services Consultant will monitor the facility compliance with entering CPR certifications into the electronic scheduling system upon hire, ensuring newly hired licensed nurses are provided the current CPR policy specifically referencing who is required to be certified when on duty. The monitoring will be quarterly ongoing with no end date at this time. The results of the monitoring will be provided to the facility quality assurance committee each quarter for review and any recommendations/feedback, or adjustments made based on results.

Completed: 03/02/2022

By Whom: Clinical Services Consultant

Completed: 03/11/2022

As part of the validation process on 06/23 through 06/24/22, the plan of correction was reviewed and included interviews with the Licensed Administrator and the Director of Nursing regarding in services they received related to the deficient practice. The Licensed Administrator and the Director of Nursing stated they had been in serviced by the Clinical Services Consultant regarding the CPR policy, initiating timely CPR, and ensuring all licensed nursing staff who work have current/valid CPR Certifications. A review of the current system for tracking CPR certifications for licensed nurses was conducted and validated. The facility policy and procedures for implementing a code blue and CPR was provided and reviewed to address the deficient practice.

The facility alleges full compliance with this plan

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F 835	Continued From page 41 of correction effective 03/11/2022.	F 835		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		8/5/22

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F 880	Continued From page 42 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to establish infection control policies, reports, testing procedures, to reduce the risk and growth and spread of Legionella in the building water systems that could affect 56 of 56 residents. Findings included:	F 880	F880 Infection Control DPOC/RCA ROOT CAUSE ANALYSIS – F880 INFECTION CONTROL Completed: By: Infection Preventionist/ DON_____ __	

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F 880	Continued From page 43 Review of the facility's Emergency Preparedness Plan and Water Safety Policy (effective 12/2021) revealed no information related to a facility water safety management program to minimize the risk of transmission of Legionella Disease (LD) to the residents, staff and visitors. In an interview on 06/23/22 at 1:30 PM. The Administrator stated she was unaware of the requirement to develop a program to minimize the risk of transmission of Legionella through the facility's water system. She stated that she spoke with the facility Maintenance Director, and he was also unaware of the requirement. She further revealed the facility's water was supplied by the city and no water testing had been completed by the facility. In an interview on 06/24/22 at 3:00 PM. The Maintenance Director stated that he had spoken with their local Hospital's Maintenance Director who told him that they sent weekly water samples to a lab that tested for Legionella. He further explained that the nursing facility could get a CDC-toolkit and test their facility's water system himself or send it off to a lab, like they do. The Facility's Maintenance Director stated he was planning to set up a meeting with the Administrator to determine how best to test their water system for Legionella, and not to rely solely on their city water department for testing.	F 880	QAPI Committee Members: DON Administrator Social Worker Dietary Manager MDS Coordinator Unit Manager Activity Director Admission Coordinator Maintenance Director Governing Board/Director of Operations: Liberty Healthcare/Amy Fann Chief Clinical Operator/Roxanne Thompson VP of operations. Define the problem/issue: The facility did not test for legionella bacteria in the water system. ¿ Why did it happen? The facility legionella policy did not specifically outline when water would be tested for legionella, thus the water had not been tested.	

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F 880	Continued From page 44	F 880	¿ Why is that? The managing corporation/governing body had not incorporated into the current Legionella policy outlining when the facility would be required to test the water for presence of Legionella. The policy outlined monitoring the temperature of the water, but did not specifically state when testing was required. . ¿ Why is that The managing corporation/governing body implemented a safe water policy/procedure that did not include a testing policy for the facility to test for legionella in the water because it was felt the policy met the current regulation. ¿ Analysis The corporation/governing body did not specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained, within the Legionella policy. ¿ Action	

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F 880	Continued From page 45	F 880	The Corporation/Governing Body designed a policy/procedure which now specifies testing protocols and acceptable ranges for control measures, to include documentation of the results of testing and corrective actions taken when control limits are not maintained. The Facility will test for legionella bacteria in water system per policy/procedure. Governing Body: Liberty Health Care Management Amy Fann - Chief of Clinical Operations Roxanne Thompson- VP of Operations Specific staff involved implementing the corrective action: Chief of Clinical Operations, VP of Operations, Medical Director, Administrator, Infection Preventionist/DON, Regional Maintenance Director Director and Maintenance Director. Identification of residents in the facility who may be included: All residents have the potential to be affected. Systemic Changes and Actions that need to be taken: On July 14th, 2022 all Quapi team members were educated by Liberty Health Cares Chief of Clinical Services on Water Management Program with updates for testing including: Control Points, Control Measures, Control Limits, Contingency Response, Corrective Action and Monitoring- a risk assessment also is	

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F 880	Continued From page 46	F 880	to be completed by the QUAPI TEAM. Risk Assessment will be update per policy and will be completed and reviewed with Medical Director and Governing body on or before 7/22/22. Monitoring: The risk assessment will guide the facility on where to take samples from within the facility. Based on the Risk Assessment some samples will be taken weekly, monthly, or as needed and tracked in the TELS system/Hard Copy by the administrator and Maintenance Director. The Administrator or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Safe Water Policy/Testing. The monitoring will include reviewing the testing results. Additionally, results will be audited- weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Dietary Manager and Social Worker.	