Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Tower Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 Bond Street Raleigh, NC 27604	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Medical Director interviews, the facility failed to utilize an Automatic External Defibrillator (AED) during the provision of Cardiopulmonary Resuscitation (CPR) when an AED was available and Nurse #1 became aware that Resident #11, who was a full code, did not have a pulse and was not breathing, and failed to maintain documentation of current, valid CPR certification for Nurse #1 on file. This deficient practice occurred for 1 of 3 residents (Resident #11) reviewed for CPR, and 1 of 8 staff (Nurse #1) whose CPR certifications were reviewed.Findings included:The facility's policy titled Cardiopulmonary Resuscitation dated 8/2012 revealed in part This facility provides the HeartSaver level of CPR as defined by the American Heart Association. Cardiopulmonary resuscitation will be initiated immediately on residents following a cardiopulmonary arrest, unless the resident has a ?Do Not Resuscitate' (DNR) order issued by the physician, or obvious signs of clinical death (including but not limited to: rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or initiating CPR could cause injury or peril to the rescuer.The American Heart Association (AHA) revealed in part the HeartSaver Courses included training in the lifesaving skills of first aid, CPR, and AED use. The facility's policy titled AED Procedure dated 4/2013 revealed in part Authorization to use AEDS: Any licensed nurse who has completed the required training in the use of AED may deploy the AED in emergency situations where a crash cart is required. Staff will continue to maintain certification in CPR and the AED will be used in tandem with CPR. Procedure: In the event of discovering an unresponsive individual or witnessing the rapid decline of any resident/individual to an unresponsive state, staff will activate the procedure for Code Blue by overhead paging Code Blue and the location of the unresponsive resident/individual three times and activating EMS [Emergency Medical Services} by calling 911. All available staff will immediately deploy the crash cart [an emergency cart containing essential equipment for use during CPR] and AED to the announced location in response to the Code Blue announcement.Resident #11 was admitted to the facility on [DATE] with a diagnosis of chronic atrial fibrillation (irregular heartbeat).A physician's order for Resident #11 dated [DATE] revealed CPR full code.Resident #11's care plan revealed a care guide section dated as initiated on [DATE] with an intervention of advance directives full code.Resident #11's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. She did not receive anticoagulant medication.A nursing progress note dated [DATE] at 6:11 AM written by Nurse #1 revealed at 5:30 AM Resident #11 was found unresponsive on morning rounds. A Code Blue was called, and CPR was initiated and continued until EMS arrived.The Wake County EMS system patient care record for Resident #11 dated [DATE] revealed the call was received at 5:38 AM. Wake County EMS system Unit DC1 arrived on the scene at 5:43 AM. Upon arrival, Unit DC 1 found Resident #11 already under the care of the Wake County EMS Unit EMS 84 and the [NAME] Fire Department who reported that facility staff had found Resident #11 in cardiac arrest and had moved Resident #11 onto the floor for CPR. Wake County Unit EMS 84 had the monitor in AED mode and no shock was advised. Resident #11 remained in asystole (the total cessation of electrical and mechanical heart activity) despite advanced life support measures. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the interim DON at the facility on [DATE] when Resident #11 experienced her cardiopulmonary arrest. She reported she worked as a mobile DON in multiple states. She stated she was not sure what the regulations were in North Carolina related to the use of an AED. DON #2 indicated her expectation would be that if a resident experienced a cardiopulmonary arrest, staff would immediately call the Code Blue, call EMS, bring the crash cart to the scene, and begin CPR. She reported that if the facility had an AED available, this should be brought with the crash cart. DON #2 stated the AED should be applied to the resident. She reported not all residents would be candidates for a shock. She indicated staff would just follow the instructions the AED gave to determine if a shock was beneficial. She reported that if the AED instructed a shock was advised, and this was delivered it could assist the resident to regain a heartbeat. On [DATE] at 4:22 PM a telephone interview with the Medical Director indicated he was familiar with Resident #11. He stated when Resident #11 was admitted to the facility, her medical condition was very complicated. He reported Resident #11 had a history of bleeding and was severely anemic (lack of healthy red blood cells reducing oxygen transport to organs). He indicated because of this bleeding, the blood thinning medication used to prevent blood clots from Resident #11's atrial fibrillation could not be given. The Medical Director stated Resident #11 refused all blood transfusions to treat her severe anemia because of her religious beliefs. He reported Resident #11's cardiopulmonary arrest on [DATE] was a rapid sequence of events. He stated staff initiated immediate and high quality CPR. He indicated EMS arrived on scene quickly. He reported he did not feel that the use of an AED by Nurse #1 and Nurse #2 on [DATE] would have changed the outcome for Resident #11. On [DATE] at 10:48 AM an interview with the Administrator indicated that the facility had an AED available for use on [DATE]. She reported because it could have taken additional time to bring the AED, she felt it was appropriate for Nurse #1 and Nurse #2 to just concentrate providing CPR until EMS arrived. She indicated the facility did not currently have a copy of Nurse #1's CPR certification on file but were attempting to obtain this.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interviews, the facility failed to adhere to enhanced barrier precautions (EBP) during catheter care for Resident #4 who had an indwelling urinary catheter. This deficient practice occurred with 1 of 4 staff members observed for infection control practices (Nurse Aide #1).Findings included:The facility's EBP police dated 4/2023 revealed in part: Enhanced Barrier Precautions (EBP) are used in conjunction with Standard Precautions to reduce the risk of MDRO (multi drug resistant organism) transmission during high-contact resident care activities. Includes the use of both gowns and gloves. EBP are meant to be in place for the duration of the resident's stay or the discontinuation of an indwelling medical device. Enhanced Barrier Precautions apply to residents with any of the following: Presence of an indwelling medical devices with or without the presence of an MDRO infection or colonization. Examples of indwelling medical devices: Indwelling Catheters.On 3/4/26 at 11:05 AM a continuous observation of indwelling urinary catheter care was conducted for Resident #4 with Nurse Aide (NA) #1. A sign was observed posted on the entry door to Resident #4's room which read in part Stop, Enhanced Barrier Precautions Everyone must: clean hands before entering and after leaving the room. All HealthCare Personnel must: Wear gloves and gown for the following High Contact Resident Care Activities: Device care or use: urinary catheter. Personal Protective Equipment (PPE) including gowns and gloves were observed at the entrance to Resident #4's room in the hall. NA #1 was observed to perform hand hygiene and enter Resident #4's room. She was not wearing a gown. She was observed to explain the procedure to Resident #4. She set up her supplies, including washcloths, towels, warm water, and soap. NA #1 was observed to perform hand hygiene and apply gloves. She assisted Resident #4 with positioning, opened his incontinence brief, and at 11:15 AM as she was preparing to use a washcloth moistened with soap and water to clean Resident #4's urinary catheter which was inserted into his penis, she was asked to stop, make Resident #4 safe, and step out into the hallway. On 3/4/26 at 11:16 AM NA #1 was interviewed after she had stepped out into the hallway. NA #1 reported she had performed urinary catheter care for Resident #4 in the past. She stated she knew Resident #4 was on EBP and indicated she had received education on EBP. She stated EBP included the use of gowns and gloves when providing catheter care to a resident. NA #1 went on to say EBP was used to protect residents from germs and prevent the spread of infections. She stated she had always followed EBP and wore a gown and gloves when she performed catheter care for Resident #4, but this time she had been nervous and had forgotten to.The facility's Infection Preventionist (IP) was not available for interview during the survey.On 3/4/26 at 11:45 AM an interview with the Director of Nursing (DON) indicated she was not the facility's IP. She stated NA #1 should have worn a gown and gloves when performing urinary catheter care for Resident #4 to prevent the spread of germs which could cause infections. She reported NA #1 was usually very good with observing EPB precautions.On 3/5/26 at 10:48 AM an interview with the Administrator indicated NA #1 should have followed EPB precautions which included the use of a gown and gloves when providing indwelling urinary catheter care to Resident #4 to prevent the spread of infections.