STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425048	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge IN Georgetown	2715 South Island Road Georgetown, SC 29440

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on record review and interviews, the facility failed to provide written notification to the resident, resident representative, and the Ombudsman, when the facility initiated a transfer/discharge for 2 of 3 residents (Resident (R)24 and R31) reviewed for hospitalization . Findings include: 1. Review of R24's Face Sheet found under the Profile Tab in the electronic medical record (EMR) revealed the resident was originally admitted to the facility on [DATE]. Review of R24's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/12/24, in the EMR under the MDS tab revealed the resident has a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. Review of R24's EMR revealed a Progress Note dated 07/01/24 at 8:32 AM, under the Progress notes tab indicated R24 was transferred to the hospital via EMS [Emergency Medical Services], due to nausea and vomiting. A subsequent note on 07/01/24 at 8:32 PM, indicated R24 was admitted to the hospital. 2. Review of R31's Face Sheet found under the Profile tab in the EMR revealed an admitted d 03/13/18, with primary diagnoses of aphasia and dysphagia. Review of R31's Quarterly MDS with an ARD of 04/29/24, in the EMR under the MDS tab, revealed the resident is severely cognitively impaired and was unable to complete the BIMS interview. Review of R31's Progress note in the EMR dated 04/14/24 at 8:43 AM, under the Progress notes tab, indicated R31 was transferred to the hospital on 04/13/24, due to difficulty breathing. Emergency Services was contacted on 04/14/24 at 9:01 PM. During an interview with the Director of Nursing (DON) on 08/14/24 at 12:20 PM, she was asked how the facility notifies the resident or resident representative of hospital transfers, and the DON stated that they are contacted via telephone. She was asked if they provide any written documentation to the resident or resident representative, and she confirmed that they only provide the Bed Hold physically to the resident or resident representative or via certified mail. In a subsequent interview on 08/15/24 at 3:30 PM, the DON confirmed that the facility does not have a policy related to hospital transfers. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview with the Ombudsman on 08/15/24 at 1:15 PM, she revealed that she recently received an email from the Administrator with all the transfer notifications from 01/01/24 through 08/13/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on record reviews, review of personnel files, interviews, and policy review, the facility failed to ensure care and services were provided in accordance with professional standards for 1 (Resident (R)77) of 3 closed records reviewed. Specifically, the facility failed to ensure nursing staff followed a resident's code status and physician order. The nursing staff performed Cardiopulmonary Resuscitation (CPR) on R77, even though the resident had selected Do Not Resuscitate (DNR). (Cross reference F835 and F867) On [DATE] at 8:45 PM, the facility's Administrator and Director of Nursing (DON) were informed that Immediate Jeopardy (IJ) existed related to the failure to provide sufficient administration to implement and monitor the facility system for communicating each residents' code status. The IJ began on [DATE], the date the Administrator failed to ensure the correct clinical operations related to code status. The IJ is related to 42 CFR 483.25 - Quality of Care. On [DATE] at 3:45 PM, the facility provided an IJ Removal Plan that was accepted. The survey team validated implementation of the removal plan through observations, staff interviews, and review of resident records and facility training records and the IJ was removed on [DATE] at 5:30 PM. The facility remained out of compliance at F684 at a lower scope and severity of D. An extended survey was conducted in conjunction with the Recertification Survey for non-compliance at F684, constituting substandard quality of care. Findings include: Review of the facility's undated policy titled, Advanced Directives indicated, Advance directives will be respected in accordance with state law and facility policy. Review of the facility's undated policy titled, Do Not Resuscitate Order indicated, Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. Review of R77's electronic medical record (EMR) revealed R77 was admitted to the facility on [DATE], with diagnoses including but not limited to: Parkinson's disease and chronic atrial fibrillation. Review of R77's Documents tab in the EMR titled Emergency Medical Services Do Not Resuscitate Order, revealed that the resident has a terminal condition and that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest. The form was signed by R77 and the facility's Medical Director on [DATE]. Review of R77's Progress Notes in the EMR under the Progress Notes tab dated [DATE] at 1:30 AM, indicated, At 2226 [10:26 PM] Code Blue initiated. Resident observed cyanotic, weak pulse, no respirations by evidence of lack of diaphragmatic movement. CPR and EMS [Emergency Medical Services] initiated at that time. After 2 minutes Resident regained consciousness and respirations observed. Shortly thereafter EMS arrived. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of employee files revealed Annual Employee In-Service which included a section on Advanced Directives, that indicated the information is easily accessible on paper medical records under the Advanced Directive Tab. The section also indicated, If a resident is found unresponsive (without pulse and respirations), call for help and follow CODE STATUS - located under Advanced Directives on chart. The section indicated that if a resident's code status is DNR Registered Nurse assess for s/s [signs and symptoms] of death and report to MD [Medical Doctor]. LPN6 was in-serviced on [DATE], LPN1 was in serviced on [DATE], and CNA2 was in-service on [DATE]. During an interview on [DATE] at 1:27 PM, R77's resident representative (RR) confirmed that the resident was transferred to the hospital on the evening of [DATE]. She stated that she was told by the hospital that CPR had been performed on the resident and she contacted the staff at the facility to let them know that R77's code status was DNR. During an interview with the Administrator and Director of Nursing (DON) on [DATE] at 2:28 PM, both stated that they were familiar with the situation. The Administrator confirmed that she was not aware of R77's code status until she arrived at the facility the morning of [DATE] at approximately 5:00 AM. She stated that upon her arrival, Certified Nursing Assistant (CNA)2 approached her. The Administrator was asked if it is the facility's policy for a CNA to initiate CPR. The Administrator stated that their policy states only nurses can initiate a code but added that after initiation any CPR qualified staff can assist. The DON confirmed that it is the policy of the facility that only nurses can initiate CPR. When asked what type of education is provided to the nursing staff to ensure all staff is aware, she stated, it is basic knowledge that nurses have to be the one to initiate CPR. During an interview with CNA2 on [DATE] at 2:55 PM, CNA2 stated that on the evening of [DATE], she was giving R77 a bed bath. CNA2 stated that she turned away to grab something, the resident had gone quiet and when she turned around, R77 was convulsing. CNA2 stated that she attempted to shake him and bring him back but after a few moments the resident fell unresponsive. CNA2 then stated that she ran to the hallway and called for help. She said that Licensed Practical Nurse (LPN)6 and LPN1 arrived at the resident's room. CNA2 stated that LPN6 stated she was going to get the crash cart. CNA2 stated that she felt no one was doing anything so she hopped on the bed and began CPR adding that she felt she was left to assist the resident alone. CNA2 confirmed that she was the only staff member to conduct CPR and she continued until a pulse could be found and the resident was responsive again. CNA2 was asked if she was aware of the R77's code status and she stated that she found out later from CNA3. In a subsequent interview with the DON on [DATE] at 3:51 PM, the DON provided documentation that an In-Service on the process for initiating a code and confirming a resident's code status was conducted on [DATE]. Per the documentation 14 staff members (seven nurses and seven CNAs) completed the in-service as of [DATE]. The Administrator was also present and was asked when she found out about the R77's code status. The Administrator stated that she found out later on [DATE], when R77's representative called to notify her that they had been advised by the hospital that CPR had been performed on the resident and wanted to clarify that R77's code status was DNR. The DON and Administrator were asked if they had done any other investigation or taken this concern to Quality Assurance and Performance Improvement (QAPI) and they both confirmed that they had not. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview via telephone on [DATE] at 6:32 PM, the Medical Director stated he was familiar with R77, who he recalled had diagnoses that included Parkinson's and atrial fibrillation. The Medical Director stated he was aware the resident was transferred to the hospital but was not aware that the resident coded or that CPR was performed. He added that he was aware of the resident having a DNR code status. On [DATE] at 3:45 PM, the facility provided an IJ Removal Plan which included the following: The resident's Electronic Medical Records have been audited by the RN Nursing Home Administrator and Director of Nursing-RN to ensure all residents or resident's representative, that have elected a code status, the orders were updated to reflect the signed medical intervention. The necessary documentation has also been copied and placed in a 3-ring binder labeled Code Status Binder for ease of access for nurses to identify residents that are FULL CODE or DO NOT RESUSCITATE on [DATE] and placed at each nurse's station. The Administrator and Director of Nursing were educated by the CEO who is also a Social Worker, LNHA and Nurse on ensuring the resident is provided advanced directives upon admission, revised PRN and at a minimum of quarterly for any updates and changes they may elect. The Administrator and DON will educate the licensed nurses and certified nursing assistants to ensure the wishes of the residents in relation to their DNR or Full Code Status are followed. The education will be completed for all licensed nurses and Certified Nursing Assistants by [DATE]. The licensed nurses and certified nursing assistants were educated on the facility's CPR/DNR policies to be completed [DATE]. They will be further instructed that a breach in a policy may result in a negative outcome, must have an investigation to include reporting to any state agency if warranted and reviewed with the monthly QAPI committee. The new licensed nurses and certified nursing assistants will be educated on the medical intervention status and location of the code status binder at each nurse's station during new hire orientation. The nurse Unit Managers will ensure the Code Status Binders and EMR are updated to reflect the residents, or RR wishes for advanced directives, PRN, upon admission and at a minimum of quarterly. The Director of Nursing or designee will audit the Code Status Binders weekly for 4 weeks, monthly for 5 months or until 100% compliance is achieved. Any code called will be reviewed by the Director of Nursing or Administrator to determine the action provided by staff. Any identified areas of concern will result in further education or disciplinary action. The Director of Nursing will review their findings with the Administrator weekly for recommendations or follow up as indicated. The Administrator and/or Director of Nursing will report the finding of the weekly and monthly audit to the Monthly Quality Assessment Performance Improvement Committee for further recommendation as indicated. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All areas will be completed by [DATE]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based on observations, record review, staff interview, and facility policy review, the facility failed to ensure 1 (Resident (R)26) of 3 residents reviewed for falls conducted a root cause analysis of each fall and appropriate interventions to help prevent further falls. These failures resulted in repeated falls after R26 returned to the facility from the hospital from a previous fall on 07/21/24. Findings include: Review of the undated facility policy titled, Falls and Fall Risk, Managing revealed, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Resident-Centered Approaches to Managing Falls and Fall Risk . if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . Monitoring Subsequent Falls and Fall Risk . The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 2. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 3. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. Review of the undated facility policy titled, Accidents and Incidents - Investigating and Reporting revealed, The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident . Review of the undated facility policy titled, Assessing Falls and Their Causes revealed, the purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall . Documentation . documentation should be included in the resident's chart that includes, appropriate interventions taken to prevent future falls. Review of R26's Census tab located in the electronic medical record (EMR) revealed R26 was admitted to the facility on [DATE], and readmitted after her hospital stay on 07/26/24. Review of the Med Diag [Medial Diagnosis] tab located in the EMR revealed R26 was admitted with a fracture of the neck of her right femur, abnormal gait, lack of coordination, unsteadiness on feet, difficulty walking, and repeated falls. Review of the Orders tab located in the EMR revealed orders for bilateral Hipsters [hip padding] to always be on as tolerated and for a floor mat to be used on the side of R26's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/15/24 and located in the EMR revealed R26 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment. The Care Assessment Area - CAA indicated triggers for functional abilities, urinary incontinence, and falls. Review of Fall Risk Evaluations under the Assessments tab located in the EMR and dated 07/29/24, 08/05/24, 08/06/24, and 08/09/24 revealed R26 was at risk for falls in each evaluation. Review of a Fall Investigation Report dated 07/29/24 provided by the Director of Nursing (DON) revealed R26 had fallen due to non-compliance and the intervention was to educate R26 with return demonstration. Review of a Fall Investigation Report dated 08/05/24 revealed R26 had fallen due to the resident does not use call bell for assistance and will frequently get up on her own. The intervention for 08/05/24 was education on the use of the call bell with verbal understanding. Review of a Fall Investigation Report dated 08/06/24 revealed R26 had fallen due to the resident is non-compliant with asking for assistance while ambulating. The 08/06/24 intervention was to reeducate R26 and to use non-skid socks. Review of a Fall Investigation Report dated 08/09/24 revealed that R26 had fallen due to the resident refuses to use call bell for assistance, still feels she can do it on her own. There was no intervention recorded on the 08/09/24 investigation. Review of the Care Plan (CP) located in the EMR under the Care Plan tab revealed a history of fall concerns/interventions beginning in February 2021. After returning to the facility on [DATE] from a hospital stay for a fractured leg, an intervention was initiated to have a floor mat to the side of the bed. The CP indicated, Fall 07/29/24 while unassisted transfer- re-educated on fall prevention and return demonstration. Interventions initiated on 07/29/24 for the 07/29 fall was to have the bed against the wall per resident preference, physical and occupational therapy to evaluate. The CP indicated a fall on 08/05/24, 08/06/24, and 08/09/24 the only intervention beginning on 08/06/24 was reeducating R26 on the use of the call bell with R26 giving a return demonstration. Observation on 08/12/24 at 1:18 PM, revealed R26 to be in her low bed with a floor mat next to the bed. R26 was not wearing hipsters. Observation on 08/13/24 at 3:00 PM, R26 was in her bed with no fall mat on the floor. R26 was not wearing hipsters. Interview on 08/14/24 at 9:20 AM, Licensed Practical Nurse (LPN)5 stated once a resident is found after an unwitnessed fall, the nurse will evaluate the resident and implement an intervention to prevent further falls and investigate the current fall to find out what happened. During the next interdisciplinary team meeting, the fall is discussed, and the care plan is updated. LPN5 stated interventions are tried and if they don't work then new ones are initiated. LPN5 verified the same intervention was tried after the 08/05, 08/06, and 08/09 falls without effect. She stated she had mentioned other interventions to the interdisciplinary team such as pressure alarms on the bed, but she was told the alarm is seen as a restraint. LPN5 stated the hipsters are used when R26 is out of the bed, and she has seen therapy use the device every time they work with R26. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/14/24 at 12:05 PM, the DON stated many interventions have been attempted with R26. The DON continued to share that R26 understands what is asked of her [R26] but chooses to do as she wants in the moment and that she [R26] should not get out of bed without calling out for assistance. The DON stated the facility addresses each of R26's falls as an individual occurrence and determines interventions from the investigation of the fall. The DON verified R26 needed supervision and suggested the facility could try frequent checks on her, however, she could not explain how added supervision was accomplished. When it comes to supervision, the DON stated the resident's room is made as safe as possible and that supervision could be increased, if necessary, but she couldn't state what form the supervision has taken or would take. The DON was not sure if a toileting study had been done even though the resident's reason for falling was listed on the investigations as coming or going to the restroom.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that 1 of 1 resident (Resident (R)27) reviewed for side rail usage had required documentation completed prior to the use of the side rails and quarterly thereafter as long as the side rails were used. Findings include: Review of facility's undated policy titled "Proper Use of Side Rails," revealed, "The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms . General Guidelines . 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. bed mobility; b. ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. risk of entrapment from the use of side rails; and that the bed's dimensions are appropriate for the resident's size and weight . 5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. 6. Less restrictive interventions that will be incorporated in care planning 8. The risks and benefits of side rails will be considered for each resident. 9. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks." Review of "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), indicated that R27 was readmitted to the facility on [DATE], with diagnoses including but not limited to: quadriplegia and muscle weakness. During an observation on 08/12/24 at 6:02 AM, R27 was in bed with the left side quarter side rail observed in the up position. Further observations on 08/13/24 at 8:30 AM, 08/14/24 at 8:30 AM, and 08/14/24 at 12:30 PM, revealed R27 was in bed with the left side quarter side rail observed in the up position. Review of R27's "Enabler Bar Assessment," located under the Assessments" tab in the EMR, dated 03/23/23, indicated "Bilateral quarter side rails." However, there was no evidence of further side rail assessments and/or evidence of alternatives tried prior to side rails usage. Review of "Bedrail-Side rails Consent Form" dated 01/17/24, located in the "Misc" tab in the EMR indicated no evidence of alternatives tried prior to side rails. During an interview with the Director of Nursing (DON) on 08/14/24 at 12:30 PM, the DON stated that side rails are being assessed quarterly with the care plan meetings, which includes going over alternatives and risk/benefits at that time. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with R27's family member on 08/14/24 at 2:04 PM, she indicated that she gave consent for the side rails to be on his bed, but the facility did not go over any alternatives, just was told that was what the facility does. During an interview with the Administrator on 08/14/24 at 4:25 PM, indicated that side rail assessments are completed yearly. The Administrator confirmed that R27 has not had a side rail assessment since 03/23/23.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based on record review, document review, job description review, staff interview and facility policy review, the facility Administrator failed to implement her job description to ensure the correct clinical operations related to resident's code status was followed. There is a potential for serious adverse outcomes because of the facility providing cardiopulmonary resuscitation (CPR) to a resident without confirming the code status, leading to possible injury. This also presents a risk for psychosocial harm related to end of life wishes for 1 of 1 resident (Resident (R)77) reviewed. (Cross reference F684 and F867) On [DATE] at 8:45 PM, the facility's Administrator and Director of Nursing (DON) were informed that Immediate Jeopardy (IJ) existed related to the failure to provide sufficient administration to implement and monitor the facility system for communicating each residents' code status. The IJ began on [DATE], the date the Administrator failed to ensure the correct clinical operations related to code status. The IJ is related to 42 CFR 483.70 - Administration. On [DATE] at 3:45 PM, the facility provided an IJ Removal Plan that was accepted. The survey team validated implementation of the removal plan through observations, staff interviews, and review of resident records and facility training records and the IJ was removed on [DATE] at 5:30 PM. The facility remained out of compliance at F835 at a lower scope and severity of D. Findings include: Review of the undated facility policy titled, Accidents and Incidents - Investigating and Reporting revealed, The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident . Review of the Licensed Nursing Home Administrator job description dated [DATE], revealed the Administrator is responsible for the overall management of the facility. The Administrator . monitors and supports all operational, administrative, clinical, customer service . for the facility's programs and services. The Administrator . ensures the quality and appropriateness of resident/patient care meets or exceeds company and regulatory standards. Review of R77's Electronic Medical Record (EMR) revealed R77 was confirmed to have a Do Not Resuscitate (DNR) order. Review of the EMR Progress Notes tab revealed a Progress Note dated [DATE] at approximately 10:26 PM, R77 became unresponsive and received CPR by Certified Nurse Aide (CNA)2 with Licensed Practical Nurse (LPN)1 and LPN6 being aware. Neither the DON nor Administrator were aware of R77's code status until the resident's family member called to inform the facility. (continued on next page)

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Blue Ridge IN Georgetown	2715 South Island Road Georgetown, SC 29440

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Quality Assurance and Performance Improvement (QAPI) monthly meeting notes dated [DATE] through [DATE] revealed that Administration did not identify an adverse event which occurred on [DATE] in which R77's code status of DNR was not followed and CPR was performed by nursing staff. Administration failed to investigate this incident in order to correct the quality deficiency and ensure the incident does not recur. Administration implemented training of only 14 out of 47 nursing staff members and stated they meant to get to everyone but had not. The facility did not implement monitoring or other interventions. During an interview on [DATE] at 4:45 PM, the Administrator confirmed she was unaware of the resident's code status until she received a call from the resident's representative on [DATE]. She stated that she had not been contacted regarding the incident and only found out when she arrived around 5:00 AM on [DATE] the morning after the incident. The DON was also present during the interview and stated she was contacted the evening of the event. The DON added that she was working with the previous DON and was told to start inservice education. During an interview on [DATE] at 7:20 PM, the DON and Administrator in Training (AIT) both stated that this type of incident would normally be investigated and reviewed in QAPI and not addressing the incident was an oversight. On [DATE] at 3:45 PM, the facility provided an IJ Removal Plan which included the following: Unable to correct for resident 77 as the resident is no longer at the facility. The residents Electronic Medical Records has been audited by the RN Nursing Home Administrator and Director of Nursing-RN to ensure all residents or residents representative that have elected Do Not Resuscitate has been updated. The necessary documentation has also been copied and placed in a 3-ring binder labeled Code Status Binder for ease of access for nurses to identify residents that are FULL CODE or DO NOT RESUSCITATE on [DATE] and placed at each nurse's station. The Administrator and Director of Nursing were educated by the CEO who is also a Social Worker, LNHA and Nurse on ensuring the resident is provided advanced directives upon admission, revised PRN and at a minimum of quarterly for any updates and changes they may elect. To include initiating an investigation if warranted. The investigation outcome if a breach of policy and procedure has been identified will include the corrective actions, staff training and monitoring of the deficient practice. The Administrator and DON will educate the licensed nurses to ensure the wishes of the residents in relation to their DNR or Full Code Status are followed. The education will be completed for all licensed nurses by [DATE]. The nurse Unit Managers will ensure the Code Status Binders and EMR are updated to reflect the residents, or RR wishes for advanced directives, PRN upon admission and at a minimum of quarterly. The Director of Nursing or designee will audit the Code Status Binders weekly for 4 weeks, monthly for 5 months or until 100% compliance is achieved. The Director of Nursing or designee will review their findings with the Administrator weekly for recommendations or follow up as indicated. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Any code called will be reviewed by the Director of Nursing or Administrator to determine the action provided by staff. Any identified areas of concern will result in further education or disciplinary action. The Administrator and/or Director of Nursing will report the finding of the weekly and monthly audit to the Monthly Quality Assessment Performance Improvement Committee for further recommendation as indicated. All areas will be completed by [DATE]

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 46592 Based on document review and interview, the facility failed to ensure the Addendum One-Arbitration Agreement located in the facility's admission packet contained all the fundamental requirements particularly indicating admission to the facility was not predicated on the resident signing the agreement and that the resident had thirty days to rescind the decision to sign the agreement. This failure has the potential to cause negative legal ramifications for all residents that signed the agreement due to the agreement not containing the regulated information. Findings include: Review of the undated facility Addendum One- Arbitration Agreement revealed the agreement did not contain information stating the resident did not have to sign the agreement for them to be admitted to the facility. In addition, instead of indicating the resident or representative has thirty days to rescind the agreement, the facility agreement stated, this Arbitration Agreement may be rescinded by written notice to the Facility from the Resident or Authorized Representative within three (3) business days of signing the Agreement. During an interview on 08/14/24 at 10:55 AM, the Administrator verified the Arbitration Agreement signed in the admission packet did not specifically state the resident did not have to sign the Arbitration Agreement as a condition of admission. The Administrator also verified the agreement indicated the resident had three business days to rescind the signed decision and not thirty days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based on record review, document review, staff interview, and facility policy review, the facility failed to take an adverse event to Quality Assurance and Performance Improvement (QAPI) for corrective action, specifically, on [DATE], facility nursing staff administered cardiopulmonary resuscitation (CPR) to 1 of 1 resident (Resident (R)77) who had a Do Not Resuscitate (DNR) order in the electronic medical record (EMR). There is a potential for serious adverse outcomes because of the facility providing CPR to a resident without confirming code status, leading to possible injury. This also presents a risk for psychosocial harm related to end of life wishes not being honored. (Cross reference F684 and F867) On [DATE] at 8:45 PM, the facility's Administrator and Director of Nursing (DON) were informed that Immediate Jeopardy (IJ) existed related to the failure to provide sufficient administration to implement and monitor the facility system for communicating each residents' code status. The IJ began on [DATE], the date the Administrator failed to ensure the correct clinical operations related to code status. The IJ is related to 42 CFR 483.75 - Quality Assurance and Performance Improvement. On [DATE] at 3:45 PM, the facility provided an IJ Removal Plan that was accepted. The survey team validated implementation of the removal plan through observations, staff interviews, and review of resident records and facility training records and the IJ was removed on [DATE] at 5:30 PM. The facility remained out of compliance at F867 at a lower scope and severity of D. Findings include: Review of the undated facility policy titled Accidents and Incidents - Investigating and Reporting revealed, The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. Review of the undated facility policy titled Quality Assurance and Performance Improvement (QAPI) Plan revealed, This facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems . objective of the QAPI plan . provide a means to identify and resolve present and potential negative outcomes related to resident care and services. Review of R77's Documents tab in the EMR titled Emergency Medical Services Do Not Resuscitate Order, revealed that the resident has a terminal condition and that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest. The form was signed by R77 and the facility's Medical Director on [DATE]. Review of R77's Progress Notes in the EMR under the Progress Notes tab dated [DATE] at 1:30 AM, indicated, At 2226 [10:26 PM] Code Blue initiated. Resident observed cyanotic, weak pulse, no respirations by evidence of lack of diaphragmatic movement. CPR and EMS [Emergency Medical Services] initiated at that time. After 2 minutes Resident regained consciousness and respirations observed. Shortly thereafter EMS arrived. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of QAPI records dated [DATE] through [DATE], revealed the Quality Assessment and Assurance (QAA) committee was not aware of this high-risk, systemic issue, and was not monitoring facility practices related to accurate and consistent communication of residents' code status is being followed. During an interview on [DATE] at 7:20 PM, the Administrator stated the facility meets for QAPI monthly in which each department identifies issues and brings a Performance Improvement Project (PIP) to QAPI for compliance evaluation or additional recommendations. The Administrator stated QAPI reviews reportable incidents. The Administrator stated QAPI uses quality measures, survey results, and accidents/incidents. The Administrator stated the incident with R77 was not brought to the attention of QAPI. The DON and Administrator in Training (AIT) both stated that this type of incident would normally be investigated and reviewed in QAPI and not addressing the incident was an oversight. On [DATE] at 3:45 PM, the facility provided an IJ Removal Plan which included the following: Unable to correct for resident 77 as the resident is no longer at the facility. The residents Electronic Medical Records has been audited by the RN Nursing Home Administrator and Director of Nursing-RN to ensure all residents or residents representative that have elected Do Not Resuscitate has been updated. The necessary documentation has also been copied and placed in a 3-ring binder labeled Code Status Binder for ease of access for nurses to identify residents that are FULL CODE or DO NOT RESUSCITATE on [DATE] and placed at each nurse's station. The Administrator and DON will educate the licensed nurses and certified nursing assistant to ensure the wishes of the residents in relation to their DNR or Full Code Status are followed. The education will be completed for all licensed nurses and certified nursing assistants by [DATE]. The Administrator and Director of Nursing were educated by the CEO who is also a Social Worker, LNHA and Nurse on ensuring the resident is provided advanced directives upon admission, revised PRN and at a minimum of quarterly for any updates and changes they may elect. They were further instructed that a breach in a policy may result in a negative outcome must have an investigation to include reporting to any state agency if warranted reviewing serious concerns with the monthly QAPI committee. The licensed nurses and certified nursing assistants were educated on the facility's CPR/DNR policies to be completed [DATE]. The nurse Unit Managers will ensure the Code Status Binders and EMR are updated to reflect the residents, or RR wishes for advanced directives, PRN upon admission and at a minimum of quarterly. The Director of Nursing or designee will audit the Code Status Binders weekly for 4 weeks, monthly for 5 months or until 100%compliance is achieved. The Director of Nursing or designee will review their findings with the Administrator weekly for recommendations or follow up as indicated. Any code status called will be reviewed by the Director of Nursing or Administrator to determine the action provided by staff. Any identified areas of concern will result in further education or disciplinary action. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator and/or Director of Nursing will report the finding of the weekly and monthly audit to the Monthly Quality Assessment Performance Improvement Committee for further recommendation as indicated. All areas will be completed by [DATE]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interviews, record review, document review, and facility policy review, the facility failed to ensure that staff wore the appropriate personal protective equipment (PPE) while providing direct care for 2 of 3 residents (Resident (R)6 and R39) reviewed for Enhanced Barrier Precautions (EBP) of 21 sample residents. This failure could promote the spread of multi drug resistant organisms throughout the facility. In addition, the facility failed to ensure that the glucometer was cleaned according to manufacturer instructions for 1 of 2 residents (R58) of 21 sample residents. This failure has the potential to promote cross contamination between residents. Findings include: Review of facility's policy titled, "Enhanced Barrier Precautions," revised 07/31/24, revealed, "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . Policy Explanation and Compliance Guidelines . 2. Initiation of Enhanced Barrier Precautions . for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers . and/or indwelling medical devices (e.g., urinary catheters) .3. Implementation of Enhanced Barrier Precautions: a. makes gowns and gloves available immediately near or outside of the resident's room . b. Personal protective equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. C. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room) . 4. High-contact resident care activities include . f. changing briefs or assisting with toileting. g. device care or use . urinary catheters. 1. During initial tour observation of the facility on 08/12/24 at 5:30 AM, there were no EBP signs posted or PPE outside the doors of residents with catheters and residents receiving tube feedings. Review of R6's "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) indicated that R6 was admitted to the facility on [DATE], with diagnoses including but not limited to: neuromuscular dysfunction of the bladder. Review of R6's "Order Summary Report" dated 08/14/24, located under "Orders" tab in the EMR indicated no evidence of enhanced barrier precautions. During a suprapubic catheter care observation with Licensed Practical Nurse (LPN)2 on 08/13/24 at 12:57 PM, LPN2 went into R6's bedroom, washed her hands and donned gloves. R6 did not have a sign outside the room indicating EBP and there was no PPE outside of the resident's room. LPN2 provided R6's catheter care, doffed her gloves and washed her hands prior to exiting the room. LPN2 did not wear any other PPE while providing catheter care. During observations on 08/13/24 at 8:30 AM, and 10:30 AM, no EBP sign and/or PPE outside R6's room door. In addition, an observation on 08/14/24 at 8:30 AM, no EBP sign and/or PPE outside R6's room door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R39's "Admission Record" located under the "Profile" tab in the EMR indicated that R39 was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's. Review of R39's "Order Summary Report" located under the "Orders" tab in the EMR, dated 08/14/24, indicated that R39 has a stage three pressure ulcer to his left buttocks. There was no evidence of an EBP order. During observations on 08/13/24 at 8:30 AM, and 2:00 PM, revealed that there were no PPE and/or EBP sign outside of R39's room. In addition, at 10:45 AM, the surveyor knocked on R39's bedroom door, a Certified Nurse Aide (CNA) answered, who was observed providing care to R39 without wearing any PPE. Further observation on 08/14/24 at 8:30 AM, revealed there was no EBP sign and/or PPE outside of R39's room door. During an interview on 08/13/24 at 11:30 AM, the Director of Nursing (DON) indicated that the facility did not have any residents on EBP in the building at the time of survey. During an interview with Licensed Practical Nurse (LPN)2 on 08/13/24 at 3:20 PM, LPN2 stated that there were no resident on EBP in the building at the time of survey. During an interview with LPN4 on 08/13/24 at 4:05 PM, she indicated that she had no knowledge of EBP. During an interview with the DON and Administrator on 08/13/24 at 4:20 PM, both indicated that they have been waiting to get a policy from corporate about EBP and that there were no residents requiring EBP in the facility at this time. The Administrator indicated that after receiving the policy it goes through quality assurance (QA) and then the nurses are educated on the precautions. 3. Review of the facility's undated policy titled "Obtaining a Fingerstick Glucose Level" revealed, "The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level . Steps in the Procedure . 3. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Review of a facility provided document titled, "Bleach Wipe" revealed, " .One step cleaner and disinfectant. Kills .Hepatitis B virus, Hepatitis C virus, and Human Immunodeficiency Virus (HIV) type 1 .Contact time: Allow surface to remain visibly wet for 30 seconds to kill bacteria and viruses on the label except a one-minute contact time is required to kill Candida albicans and Trichophyton interdigital, and a three-minute contact time is required to kill Clostridium difficile spores." Review of a facility provided document titled "Proper Storage of Diabetic Supplies" revealed, " .Glucometers should be properly cleaned following manufacturer's guidelines." Review of the facility provided In-Service Attendance Record titled, Proper Storage of Diabetic Supplies dated 01/25/24, revealed no evidence that LPN1, LPN3, or LPN4 attended the inservice. Review of R58's Admission Record" located under the "Profile" tab in the EMR indicated that R58 was admitted to the facility on [DATE], with diagnoses including but not limited to: type 2 diabetes mellitus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 08/12/24 at 5:50 AM, LPN1 removed the glucometer from the medication cart, and without cleaning it, took it into R58's room, placing the glucometer on R58's overbed table without a barrier. LPN1 donned gloves and obtained R58's blood sugar. LPN1 exited R58's bedroom, placed the glucometer on top of the medication cart, without a barrier, then wiped it with an alcohol wipe. LPN1 then placed the glucometer back inside the medication cart. During observation on 08/13/24 at 10:46 AM, LPN3 obtained the glucometer from a clear cup on top of the medication cart, and without cleaning it, entered R58's bedroom. LPN3 placed the glucometer directly onto R58's overbed table without a barrier. After obtaining R58's blood sugar, she exited R58's bedroom. LPN3 placed the glucometer directly on top of the medication cart while she added R58's blood sugar results into the EMR. LPN3 picked up the glucometer and placed it back into a clear cup on top of the medication cart without cleaning the glucometer. During an interview on 08/13/24 at 4:05 PM, LPN4 indicated that there are two glucometers on each medication cart, so that when one is drying, the other one can be used. LPN4 stated that the glucometers should be cleaned with bleach wipes which are kept on the medication carts. During an interview on 08/13/24 at 4:20 PM, the DON indicated that each glucometer should start off clean at the beginning of the shift and that each medication cart has two glucometers so that they can be rotated for usage. The DON indicated after using the glucometer, nurses should clean the glucometer with a bleach wipe, which is kept in each medication cart. Also, the DON indicated that the nurses have been instructed to read the bleach wipe information because of the different contact times, ranging from one to three minutes. The DON confirmed there should be a barrier down when placing the glucometer on a resident's overbed table or directly on the medication cart.