STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri State Health and Rehabilitation Center	600 Shawanee Rd Harrogate, TN 37752

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35460 Based on medical record review, facility investigation review, observations, and interviews the facility failed to ensure 2 residents (Resident #1 and Resident #2) were free from abuse of 5 sampled residents. The findings include: Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Aphasia, Hemiplegia and Hemiparesis affecting Dominate Right Side, Seizures, and Atherosclerotic Heart Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 9 on the Brief Interview Mental Status (BIMS) assessment which indicated moderate cognitive impairment. Review of the comprehensive care plan for Resident #1 dated 3/11/2024, revealed the facility added a focus of a psychosocial well-being problem for Resident #1 with the intervention of a stop net to resident's door entry into his room. Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Non-Rhematic Aortic (valve) Stenosis, Alzheimer's Disease, and Anxiety Disorder. Review of the quarterly MDS assessment dated [DATE], revealed Resident #2 had short and long term memory problems and used a wheelchair for mobility. Medical record review of the comprehensive care plan for Resident #2 revised on 2/12/2024, revealed Resident #2 was at risk for elopement due to wandering behavior. The care plan was revised on 3/7/2024 with the intervention of one-on-one supervision for 24 hours. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility investigation dated 3/7/2024 revealed Registered Nurse (RN) A heard Resident #1 yelling. As the nurse entered the room Resident #2 was seated in her wheelchair and had blocked the doorway. Resident #1, also seated in a wheelchair, reached out with his left hand and foot in attempt to push Resident #2 back into the hallway. During the maneuver Resident #1's open hand grazed Resident #2's face. As RN A pulled Resident #1 out of the doorway she reached out and smacked Resident #2 on the leg. The residents were immediately separated and assessed for injury with none noted. Resident #1 was placed with one-on-one supervision for 24 hours and continued with every 15 minute checks for 48 hours. A Velcro stop sign was placed across Resident #1's doorway to prevent unwanted visitors from entering. During an interview on 9/9/2024 at 11:45 AM, RN A confirmed Resident #2 had reached out to push Resident #1 out of his doorway and grazed her face. Resident #2 had reached for Resident #1's shoulder to push her back. Continued interview revealed Resident #1 had reached out and smacked Resident #2 on his leg as she pulled her out of his doorway. Further interview confirmed she had conducted skin assessments for both residents with no redness noted or injury noted. During an observation on 9/9/2024 at 1:00 PM, revealed Resident #2 propelled himself in his wheelchair. The resident was observed in different areas throughout the facility, interacted with other residents and staff with no behaviors noted. During an interview on 9/9/2023 at 2:45, RN B stated Resident 1 .likes his space he has never been resistant to care or refused medications . Resident #2 .would be up in her wheelchair and roll around when she felt okay . During a telephone interview on 9/9/2024 at 6:15 PM, Licensed Practical Nurse (LPN) C stated Resident #1 did not have behaviors of being aggressive, he was at times loud and would curse. During an interview on 9/11/2024 at 11:15 AM, LPN D stated Resident #2 was always confused and had good days and bad days. Continued interview revealed the resident propelled herself in her wheelchair, but did not know who or where she was. Further review revealed the resident was combative with care and refused medications at times. During an interview on 9/9/2024 at 10:00 AM, the Adminisrator confirmed the resident to resident altercation had occurred.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39794 Based on facility policy review, medical record review, and interview, the facility failed to develop and implement a care plan to include the code status for 4 residents (Residents #3, #8, #9, and #10) of 5 residents reviewed for care plans. The findings include: Review of the facility policy titled, Care Planning - Interdisciplinary Team, dated ,d+[DATE], revealed .The interdisciplinary team (IDT) is responsible for the development of resident care plans .Resident care plans are developed according to the time frames and criteria established .Comprehensive, person-centered care plan are based on resident assessment and developed by an interdisciplinary team (IDT) .The IDT includes but is not limited to .the resident's attending physician .a registered nurse with responsibility for the resident . to the extent practicable, the resident and/or the resident's representative . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Chronic Congestive Heart Failure, Muscle Weakness, Diabetes Mellitus, and Systemic Lupus Erythematosus. Review of a Physician's order for Resident #3 dated [DATE], revealed .CPR [Cardio-Pulmonary Resuscitation]/Full Code . Review of the initial care plan for Resident #3 dated [DATE], revealed the resident's code status for CPR/Full Code had not been developed or implemented on the care plan. Continued review revealed the care plan was not developed or implemented for a Do Not Resuscitate (DNR) code status order after the resident made a change on [DATE]. Review of the Tennessee Physician Orders for Scope of Treatment (POST) form dated [DATE], revealed Resident #3 selected .Do Not Attempt Resuscitation (DNR/no CPR) (Allow Natural Death) . The POST form was signed and dated by the Physician on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 13 on the Brief Interview Mental Status (BIMS) assessment which indicated Resident #3 was cognitively intact. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic Respiratory Failure with Hypoxia, Dysphagia, Muscle Weakness, Cognitive Communication Deficit, Chronic Obstructive Pulmonary Disease, Diabetes, Obstructive Sleep Apnea, Neuromuscular Dysfunction of the Bladder, Bipolar Disorder, Atrial Fibrillation, and History of Stroke. Review of a POST form dated [DATE], revealed Resident #8 had selected CPR. The form was signed and dated by the physician on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan for Resident #8 dated [DATE], revealed the resident's code status for CPR/Full Code had not been developed or implemented on the care plan. Review of a physician's order for Resident #8 dated [DATE], revealed the resident had an order for CPR/Full Code. Review of the admission MDS assessment dated [DATE], revealed Resident #8 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Medical record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Dysphagia (Difficulty Swallowing), Cerebral Infarction (Stroke), Protein Calorie Malnutrition, Diabetes, Anemia, Dementia, Chronic Kidney Disease Stage 2, and Chronic Obstructive Pulmonary Disease. Review of a POST form dated [DATE], revealed Resident #9 selected CPR. The POST form was signed and dated by the physician on [DATE]. Review of a physician's order for Resident #9 dated [DATE], revealed the resident had a CPR/Full Code status. Review of the comprehensive care plan for Resident #9 dated [DATE], revealed the resident's code status for CPR/Full code had not been developed or implemented on the care plan. Review of the admission MDS assessment dated [DATE], revealed Resident #9 scored a 5 on the BIMS assessment which indicated severe cognitive impairment. Review of the hospital admission orders, to the facility, for Resident #10 dated [DATE], revealed .ADMIT .TO [Facility] .FOR SHORT TERM .ON [DATE] .admitted TO HOSPICE WITH DIAGNOSIS OF PARKINSONS . FULL CODE . Medical record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Diabetes, Severe Protein-Calorie Malnutrition, Dementia with Psychotic Disturbance, and Major Depressive Disorder. Review of a POST form dated [DATE], revealed Resident #10 selected CPR. The form was signed and dated by the physician on [DATE]. Review of a physician's order for Resident #10 dated [DATE] (3 days prior to admission, obtained from the POST form), revealed the resident had a CPR/Full Code status. Review of the comprehensive care plan dated [DATE], revealed Resident #10 had a terminal diagnosis related to Parkinson's Disease and received hospice services. Continued review revealed the resident's code status had not been developed or implemented on the care plan. Review of the admission MDS assessment dated [DATE], revealed Resident #10 scored a 6 on the BIMS assessment which indicated severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:20 PM, Registered Nurse (RN) F MDS Coordinator stated at the end of , d+[DATE] an audit was performed on care plans. The audit identified the residents' code status was not entered on the care plan due to the template used in the electronic medical record. RN F MDS Coordinator confirmed the code status for Residents #3, #8, #9, and #10 had not been developed and implemented on the resident's care plans.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 39794 Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to ensure a resident's end of life wishes were honored and failed to identify staff were not appropriately trained and certified in Cardio-Pulmonary Resuscitation (CPR) before performing CPR for 4 residents (Resident #3, #8, #9, and #10) of 5 residents reviewed for Cardio-Pulmonary Resuscitation (CPR) and code status. The facility failed to ensure staff followed Resident #3's end of life wishes and failed to ensure staff were trained and certified before performing CPR on Resident #8 on [DATE], Resident # 9 on [DATE], and on Resident #10 on [DATE].The facility failed to ensure staff were educated and knowledgeable when Certified Nursing Assistants (CNAs) and Housekeeping Staff, who were not CPR certified, expressed an intent to perform CPR without having the adequate training in the event of cardiac or respiratory arrest of a resident. The facility's failure placed Residents #3, #8, #9, and #10 in Immediate Jeopardy (IJ), (A situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) when CPR was performed against a resident's wishes, when untrained, non-CPR certified staff performed CPR on 3 residents, and when untrained, non-CPR certified staff expressed an intent to perform CPR should the need arise, and had the potential or likelihood to affect all residents of the facility. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy at F-678 on [DATE] at 3:30 PM. The facility was cited Immediate Jeopardy at F-678 at a scope and severity of K which constituted Substandard Quality of Care. The facility was cited Immediate Jeopardy at F-726, F-835, F-837, and F-867 at a scope and severity of K. A partial extended survey was conducted onsite from [DATE] through [DATE]. An acceptable Removal Plan which removed the immediacy was provided by the facility on [DATE] at 8:38 PM for F-678. The IJ began on [DATE] and continued through [DATE]. The IJ ended on [DATE] and was removed on site. The corrective actions were validated on site by the surveyor on [DATE] for F-678. Noncompliance continues at F-678 at a scope and severity of E. The facility is required to submit a Plan of Correction. The findings include: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled, Resident Rights, dated ,d+[DATE], revealed .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . self-determination .exercise his or her rights as a resident of the facility and as a resident or citizen of the Unites States .be supported by the facility in exercising his or her rights . Review of the facility policy titled, Cardiopulmonary Resuscitation (CPR), dated ,d+[DATE], revealed .If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency services .in accordance with the resident's advance directives .Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills . Review of the facility job description of a Certified Nursing Assistant (CNA) dated [DATE], revealed . POSITION SUMMARY: The primary purpose of your job position is to provide each of your assigned residents .services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors .Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors .Perform special treatment as instructed .Inform the nurse Supervisor/Charge Nurse of any changes in the resident's condition so that appropriate information can be entered on the resident's care plan . Review of the facility job description of Laundry Staff personnel dated [DATE], revealed .POSITION SUMMARY: The primary purpose of your job position is to perform the day-to-day activities of the Laundry Department in accordance with current federal, state, and local standards .Duties and Responsibilities . Adheres to and assures compliance with Code of Conduct, facility policies and procedures and all applicable rules, regulations and standards as promulgated by Federal, State, and accrediting agencies or regulating bodies. This includes .Centers of Medicare and Medicaid Services [CMS], and other applicable regulatory agencies .Assure that the residents' rights to .self-determination, individuality .maintained at all times . 1. The facility failed to ensure Resident #3's end of life wishes for Do Not Resuscitate (DNR) were honored when CPR was performed on [DATE]. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Chronic Congestive Heart Failure, Muscle Weakness, Diabetes Mellitus, and Systemic Lupus Erythematosus. Review of a Physician's order for Resident #3 dated [DATE], revealed CPR/Full Code. Review of the Tennessee Physician Orders for Scope of Treatment (POST) form dated [DATE], revealed Resident #3 selected .Do Not Attempt Resuscitation (DNR/no CPR) (Allow Natural Death) . The POST form was signed and dated by the Physician on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 13 on the Brief Interview Mental Status (BIMS) assessment which indicated Resident #3 was cognitively intact. Review of the Medication Administration Record (MAR) on the electronic medical record (EMR) dated for the month of ,d+[DATE], revealed .CPR/Full code . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility document titled, CPR/Code Blue Documentation, dated [DATE], revealed Resident #3 was . discovered unresponsive in the dining room at 1:20 PM .CPR was initiated at 1:21 PM .Physician and son [message left to return call] notified by phone at 1:30 PM .CPR was paused at 1:38 PM with return of respirations .residents' [resident's] son returned call at 1:42 PM wanted to continue the DNR status and did not want the resident sent to the hospital. Review of a facility investigation for Resident #3 dated [DATE], revealed the facility notified the Physician and family of the event (where CPR was performed on Resident #3 against the resident's end of life wishes), conducted a Quality Assurance Performance Improvement (QAPI) meeting, and determined the Root Cause Analysis (RCA) for the event was the failure of staff to enter the new physician's order from the POST form for a DNR status dated [DATE], in the EMR. During an interview on [DATE] at 10:00 AM, Registered Nurse (RN) F revealed she was in the conference room when she heard the code blue called (indicating the need for CPR) to Resident #3's room. RN F responded to Resident #3's room. Continued interview revealed RN F told Licensed Practical Nurse (LPN) D she would continue the chest compressions and RN G continued with the respirations. Further interview confirmed they paused with the 2nd round of CPR to check for a pulse and respirations and observed Resident #3 was breathing on her own, had a weak pulse, and CPR was stopped. During an interview on [DATE] at 10:15 AM, RN G revealed the Housekeeper stepped out of the dining room and asked for help. Continued interview revealed RN A checked the EMR and stated Resident #3 was a full code. Further interview revealed RN G called 911 for assistance and RN A paged over head for a code blue. Continued interview confirmed LPN D began chest compressions and RN G initiated respirations with the ambu bag (a manual medical device used to force air into the lungs in emergent situations when someone is not breathing or having difficulty in breathing). During an interview on [DATE] at 10:30 AM, the Assistant Director of Nursing (ADON) stated she reported to Resident #3's family what had occurred (the facility had performed CPR on Resident #3 against her wishes), and since Resident #3 had chosen to have a DNR status and did not want CPR performed, the family did not want the resident transferred to the hospital. During an interview on [DATE] at 10:40 AM, the Social Services Director (SSD) stated she was on duty and heard the code blue called for Resident #3. The SSD stated she printed out the paperwork for Emergency Medical Services (EMS) which included the resident's face sheet, current MAR, and POST form. Continued interview revealed while printing the documentation, she realized Resident #3 had requested not to have CPR and had a DNR code status. The SSD stated after she printed the POST form, she immediately took it to Resident #3's room and notified the nursing staff of the DNR. Further interview revealed the nurses had already stopped CPR because the resident had resumed breathing and had a pulse. Continued interview revealed the DON and ADON were in the room and stated they would notify the family of the event. During an interview on [DATE] at 10:50 AM, the Housekeeper stated she noticed Resident #3 seated in her wheelchair with her head tilted back and her lips appeared purple. Continued interview revealed she called a co-worker in the dining room to come and assess the resident. Further interview revealed the Housekeeper yelled out the door of the dining room that help was needed. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:00 AM, the Medical Records Director stated she was responsible for obtaining a signature from the Physician on a POST form, she scanned the POST form into the EMR, then gave the form to the nurse to enter the order in the EMR. The Medical Records Director stated the facility's process was not followed and the order for Resident #3's code status was not changed from a Full code status to a DNR code status on [DATE]. During an interview on [DATE] at 11:15 AM, the Admissions Director confirmed she had spoken with Resident #3 on [DATE] and completed the POST form at which time the resident indicated she did not want CPR to be performed if she had no pulse and no respirations. Continued interview revealed she had given the form to the Medical Records Director to obtain the Physicians signature. During an interview on [DATE] at 11:15 AM, LPN D revealed RN A announced Resident #3 was a full code. Continued interview revealed she started chest compressions and RN G initiated respirations with the ambu bag. Further interview confirmed RN F entered the room and took over the chest compressions. During an interview on [DATE] at 2:13 PM, the DON stated it was her expectation for residents found unresponsive for Registered or Licensed nursing staff to verify the resident's code status before performing CPR. During an interview on [DATE] at 12:15 PM, the Clinical Resources Director stated it was his expectation for a resident's end of life wishes or POST form be followed. 2. The facility failed to identify staff were not appropriately trained and certified in CPR before performing CPR on Resident #8 on [DATE], Resident # 9 on [DATE], and on Resident #10 on [DATE]. Review of employee's online training record transcript and personnel files on [DATE] and [DATE], revealed CNA A, CNA C, CNA G, and CNA N did not have a current CPR certification. 2a. CNA N, who was not certified in CPR, performed CPR on Resident #8 on [DATE]. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic Respiratory Failure with Hypoxia, Dysphagia, Muscle Weakness, Cognitive Communication Deficit, Chronic Obstructive Pulmonary Disease, Diabetes, Obstructive Sleep Apnea, Neuromuscular Dysfunction of the Bladder, Bipolar Disorder, Atrial Fibrillation, and a history of Stroke. Review of a POST form for Resident #8 dated [DATE] (from previous admission to the facility), revealed the form was signed and dated by the physician on [DATE]. Continued review revealed Resident #8 requested CPR and full treatment. Review of the comprehensive care plan for Resident #8 dated [DATE], revealed the resident had an activities of daily living (ADL) deficit and required the assistance of 1 staff member. Continued review revealed no documentation of Resident #8's code status or preference for CPR/Full Code or DNR. Review of a Physician's order for Resident #8 dated [DATE], revealed the resident had an order for CPR/Full Code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the admission MDS assessment dated [DATE], revealed Resident #8 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Review of a nurse's note for Resident #8 dated [DATE], revealed .[Resident #8] was found unresponsive at 0555 [5:55 AM]. no heart rate or respirations were noted. chest compressions started, EMS [Emergency Medical Services] and [Hospital] notified. EMS arrived at 0611 [6:11 AM]. Attempted to contact wife with no success. resident was pronounced deceased at 0632 [6:32 AM] and resuscitation was stopped . (EMS pronounced death of Resident #8). Review of a facility document for Resident #8 titled, CPR/Code Blue Documentation, dated [DATE], revealed the document was completed by LPN H. The event (cardiac arrest situation for Resident #8) which occurred at 5:55 AM was unwitnessed. EMS was called at 5:55 AM and arrived at the facility at 6:11 AM. The document noted RN D and LPN H participated in the code. Resident #8 was pronounced deceased at 6:32 AM. Review of the facility staff time punches dated [DATE], revealed RN D, RN E, LPN D, CNA K, and CNA N were on duty at the time of the code situation for Resident #8. During an interview on [DATE] at 4:39 PM, RN D stated on [DATE] Resident #8 was found unresponsive at shift change. RN D stated CNA K and CNA N assisted with the code but could not recall who had initiated CPR. RN D stated he printed off the necessary paperwork to provide to EMS and then joined the code in progress while awaiting EMS arrival. RN D stated he verified Resident #8 was a full code and either RN D or LPN H advised the staff Resident #8 was a full code and to continue the code.I [RN D] believe we checked the Code status before starting CPR . RN D stated LPN D, CNA K and CNA N (CNA N was not CPR certified) assisted with the chest compressions until EMS arrived. RN D stated he was CPR certified and was unsure if the other staff who participated in the code were CPR certified. During a telephone interview on [DATE] at 5:05 PM, CNA K stated she participated in Resident #8's code on [DATE]. CNA K stated she had just arrived on shift, was in the break room, and was advised by the previous shift staff Resident #8 was found unresponsive and a code blue was called. CNA K stated she and CNA M . grabbed the crash cart [located in the break room] and went to the room [Resident #8's room] . CNA K stated RN E, LPN D, and RN D were already in Resident #8's. CNA K stated she heard another nurse yell down the hall that Resident #8 was a full code. CNA K stated CPR was initiated by RN E and after a few minutes, she took over chest compressions from RN E. CNA K stated CNA N (CNA N was not CPR certified), LPN D, and RN D also took turns with the ambu bag and chest compressions until EMS arrived. CNA K stated she was CPR certified and was unsure if the other staff who participated in the code were certified. During a telephone interview on [DATE] at 5:35 PM, CNA N stated she did not usually participate in codes except to assist the nurses in the resident's rooms. CNA N stated there was a code with a male resident a few months ago (was unable to recall the resident's name or date, later determined it was Resident #8). CNA N stated .I did put my hands on him, they [unable to recall the staff who requested assistance] asked me to .I don't really remember the situation. I left after the ambulance came . CNA N stated she was not trained or certified in CPR and further stated she was aware CPR was only to be performed by trained staff. CNA N stated .I only had my hands on him a few minutes just to help out .the other people in the room did most of it . I remember a Code Blue was called but I don't remember anyone saying, if he [Resident #8] was a full code or anything . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri State Health and Rehabilitation Center	600 Shawanee Rd Harrogate, TN 37752

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2b. CNA A and CNA G, who were not CPR certified, performed CPR on Resident #9 on [DATE]. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Dysphagia (Difficulty Swallowing), Cerebral Infarction (Stroke), Protein Calorie Malnutrition, Diabetes, Anemia, Dementia, Chronic Kidney Disease Stage 2, and Chronic Obstructive Pulmonary Disease. Review of a POST form for Resident #9 dated [DATE], revealed the form was signed and dated by the physician on [DATE] for CPR and full treatment. Review of a physician's order for Resident #9 dated [DATE], revealed the resident had a full code status (CPR). Review of the comprehensive care plan for Resident #9 dated [DATE], revealed the resident required total staff assistance, had a tube feeding, and had a desire to return home. Continued review revealed no documentation of Resident #9's code status or preference for CPR/Full Code or DNR. Review of the admission MDS assessment dated [DATE], revealed Resident #9 scored a 5 on the BIMS assessment which indicated severe cognitive impairment. Review of the facility document for Resident #9 titled, CPR/Code Blue Documentation, dated [DATE], revealed the form was completed by LPN E. The event (cardiac arrest situation for Resident #9) which occurred at 4:15 AM was unwitnessed. EMS was called at 4:15 AM and arrived at the facility at 4:50 AM. The document noted LPN E and LPN G participated in the code. Resident #9 was pronounced deceased at 4:50 AM. Review of a nurse's note for Resident #9 dated [DATE] at 5:43 AM, revealed .0415 [4:15 AM] resident [Resident #9] with no visible signs of life no vital signs. CPR initiated .EMS notified .EMS arrived at 0425 [4:25 AM]. CPR continued. EMS notified [hospital emergency room (ER) physician] .of the above and [hospital physician] .called deceased [pronounced death of Resident #9] at 0450 [4:50 AM] called resident daughter no answer. Left message to return call [Medical Director] .notified . Review of the facility time punches dated [DATE], revealed LPN E, LPN G, CNA A, and CNA G were on duty at the time of the code situation for Resident #9. During an interview on [DATE] at 9:00 PM, CNA A stated he was not CPR certified. CNA A stated if a resident was observed without a heart rate and no respirations, he would call for help and immediately start CPR until a nurse or other staff took over. CNA A stated if the nursing staff advised that the resident had a DNR status, then CPR would be stopped, immediately. CNA A stated he had participated in a Code Blue situation with Resident #9 .a few weeks ago . CNA A stated he started chest compressions and assisted with the code until the paramedics arrived.I remember because he was frail and we crushed his ribs .you could feel it and hear it .[fractured ribs was unable to be determined] . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:30 PM, CNA G stated he was unsure if his CPR certification had expired .but I think so . CNA G stated if he observed a resident without a heartbeat or was not breathing, he yelled Code Blue and initiated CPR until other staff arrived with the crash cart. CNA G stated the staff usually initiated CPR and if the nurse notified the staff that a resident was a DNR, then CPR would be immediately stopped. CNA G stated he had participated in several codes in the past few months at the facility but was unable to recall exact dates or names of residents. CNA G stated the last code he participated in was a male resident that happened about a month ago (later determined it was Resident #9) and he and another nurse (LPN G) initiated CPR. CNA G stated CNA A also assisted with chest compression to help relieve staff. LPN E went to check Resident #9's code status, came back to the resident's room, stated Resident #9 was a full code, and CPR was continued until EMS arrived. CNA G stated he performed chest compressions and knew how to perform CPR due to being previously CPR certified (date of last CPR certification was unknown). During an interview on [DATE] at 11:15 AM, LPN G stated she was CPR certified and had participated in many code situations. The last code she participated in was with Resident #9 on [DATE]. During a telephone interview on [DATE] at 4:04 PM, LPN G stated on [DATE], Resident #9 was found unresponsive by 1 of the CNA's (CNA A).We [LPN G and CNA G] went running down [to Resident #9's room] and we checked him, and we [LPN G and CNA G] proceeded to code him [CNA G was not trained or CPR certified]. I knew he was a full code, and someone went to call EMS . LPN G stated CNA G and CNA A relieved her and assisted with chest compressions until LPN E arrived to help. LPN G stated LPN E, LPN I, CNA A, and CNA G assisted in performing CPR with chest compressions or the ambu bag until EMS arrived to take over the code. LPN G stated EMS notified the hospital ER physician and Resident #9 was pronounced deceased by EMS at the facility at 4:50 AM. 2c. CNA C, who was not CPR certified, performed CPR on Resident #10 on [DATE]. Review of hospital admission orders for Resident #10 dated [DATE], revealed .ADMIT .TO [Facility] .FOR SHORT TERM .ON [DATE] .admitted TO HOSPICE WITH DIAGNOSIS OF PARKINSONS .FULL CODE . Review of a POST form for Resident #10 dated [DATE], revealed the form was signed and dated by the physician on [DATE] for CPR and full treatment. Review of the facility s Physician's Order Summary Report for Resident #10 dated [DATE] (3 days prior to admission, obtained from the POST order), revealed the resident had a CPR/Full Code status. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Diabetes, Severe Protein-Calorie Malnutrition, Dementia with Psychotic Disturbance, and Major Depressive Disorder. Review of the comprehensive care plan dated [DATE], revealed Resident #10 had a terminal diagnosis related to Parkinson's Disease and received hospice services. Continued review revealed no documentation of Resident #10's code status or preference for CPR/Full Code or DNR. Review of a Social Service Note dated [DATE], revealed Resident #10 was admitted to the facility for a 30-day short-term respite stay under hospice services. Resident #10 was alert to person and planned to discharge home after the respite stay. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the admission MDS assessment dated [DATE], revealed Resident #10 scored a 6 on the BIMS assessment which indicated severe cognitive impairment. Review of a nurse's note for Resident #10 dated [DATE], revealed the resident was noted to be unresponsive and without a pulse. CPR was initiated at 4:05 PM and EMS was notified. Resident #10 was transferred out of the facility by EMS at 4:40 PM. Review of a facility document for Resident #10 titled, CPR/Code Blue Documentation, dated [DATE], revealed the document was completed by RN E. The event (cardiac arrest situation for Resident #10) which occurred at 4:00 PM was unwitnessed. EMS was called at 4:00 PM and arrived at the facility at 4:40 PM. The document noted RN E performed CPR. Resident #10 was transferred to hospital via (by way of) air support and expired at the hospital at 5:59 PM on [DATE]. Review of a nurse's note for Resident #10 dated [DATE] at 6:30 PM, revealed the hospital called the facility and notified the staff Resident #10 had passed away at the hospital. Review of the facility time punches dated [DATE], revealed RN E, CNA C, and CNA O were on duty at the time of the code situation for Resident #10. During an interview on [DATE] at 9:38 PM, CNA C stated approximately 2 weeks ago (actual date was [DATE]) a male resident (later determined to be Resident #10) was found with no pulse, the nurse was notified, and CPR was initiated. CNA C stated she performed CPR until another nurse verified the code status and was told CPR was to be continued. During an interview on [DATE] at 10:48, LPN D stated she was CPR certified and had participated in a code with Resident #10 approximately ,d+[DATE] weeks ago. LPN D stated Resident #10 was getting his nails done, went into a cardiac arrest, and CPR was initiated. LPN D stated .I thought I remembered him [Resident #10] being a Full Code .so we [LPN D and CNA C] [CNA C was not trained and not CPR certified] went ahead and started CPR . LPN D stated another staff member (could not remember the name) did verify on the EMR, Resident #10 .was a full code and so we continued CPR until EMS arrived .I know if you start CPR on someone who is a DNR you are going to be in trouble .that happened here before .so I am glad he was a full code when the other nurse checked .but I thought I remembered him being a full code . During a telephone interview on [DATE] at 4:19 PM, RN E stated she and another nurse were in the front lobby talking and one of the CNA's said Resident #10 was not responding and did not know his code status. RN E stated Resident #10's code status was checked by the resident's primary nurse, LPN D, who was at the nurse's station. RN E stated it was unknown who initiated CPR on Resident #10. RN E stated 911 was called and after EMS arrived, she went to Resident #10's room and observed another RN, LPN D, and a few CNAs in the room. RN E stated CNA C and CNA O helped with the ambu bag but was unsure if they performed chest compressions. RN E stated EMS .worked on him [CPR] for ,d+[DATE] minutes and they were going to pronounce him .the ER doctor said to pronounce him .and then they went to unhook him [remove monitors and Automatic External Defibrillator [AED] and he [Resident #10] started breathing . RN E stated the resident was transferred by life flight to the hospital. RN E stated the facility received a call from the hospital a short time after the resident was transported and was advised the resident had expired. (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 4:34 PM, CNA C stated on [DATE], another CNA found Resident #10 unresponsive and .she went and got the room ready and me [CNA C] and another CNA [CNA O] got the crash cart out of the break room and took it down to his [Resident #10's] room .One of the nurse's started CPR but I don't know their name .I [CNA C] think I am CPR certified [CNA C was not trained or CPR certified] or I think I was and I helped them .I relieved one of the nurse's and did chest compressions on him [Resident #10] until the ambulance got here .I can't remember if he was taken out or pronounced here . During review of employee's online training record transcript, personnel files, CPR Certifications, and interview on [DATE] at 5:30 PM, the DON confirmed CNA A, CNA C, CNA G, CNA N, and CNA O were not CPR certified. During a telephone interview on [DATE] at 9:33 PM, CNA O stated she was not CPR certified and had participated in codes when the staff needed help. CNA O stated she was unable to recall the last code she had participated in and could not recall the resident's name. During interviews with staff during the survey, it was determined CNA O participated in CPR for Resident #10 on [DATE]. 3. CNAs and Housekeeping Staff, who were not CPR certified, expressed an intent to perform CPR without having the adequate training or certification, in the event of cardiac or respiratory arrest of a resident. During an interview on [DATE] at 9:15 PM, CNA B stated she was unsure if she had a valid CPR certification but did not think so. CNA B stated if a resident was observed with no heartbeat and no respirations, the nurse would be notified, a Code Blue would be called, and she would immediately initiate CPR. CNA B stated if the nurse advised the resident had a DNR status, then CPR would be stopped. CNA B stated, .we [CNAs] I think we are not supposed to start CPR on our own but by in my heart and I think I would have to start .I think you should have to start CPR, to help them .yeah, I would do it until the nurse got there . Review of CNA B's training record on [DATE], revealed CNA B was not CPR certified. During an interview on [DATE] at 9:48 PM, CNA E stated she was not CPR certified. CNA E stated she was aware of what CPR and DNR meant from CNA class. CNA E stated if a resident was observed with no heartbeat, she would call for help and start CPR and would either continue CPR or stop depending on what the nurse said. Review of CNA E's training record on [DATE], revealed CNA E was not CPR certified. During an interview on [DATE] at 9:55 PM, Laundry/Housekeeper A stated she was not CPR certified. Laundry/Housekeeper A stated if a resident was observed with no heartbeat, the nurse would be notified, and she would start CPR until someone arrived to say stop. Laundry/Housekeeper A stated the nurse would have to advise her if a resident had a Full Code Status or was a DNR because she did not have access to the EMR and did not know where else to get the information. Review of Laundry/Housekeeper A's training record on [DATE], revealed Laundry/Housekeeper A was not CPR certified. (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:25 PM, CNA F stated she was not CPR certified. CNA F stated although she was not CPR certified, if the facility was shorthanded, she would initiate CPR or help with CPR. Review of CNA F's training record on [DATE], revealed CNA F was not CPR certified. During an interview on [DATE] at 2:13 PM, the DON stated it was her expectation that all staff who perform CPR be CPR certified. The DON further stated she had not been made aware untrained staff had performed CPR and was not aware untrained, Non-CPR certified staff expressed the intent to perform CPR. During a telephone interview on [DATE] at 2:30 PM, the Medical Director stated all staff who perform CPR should be trained to do CPR with Basic Life Support to be able to use the ambu bag and CPR and know to call 911. The LPN or RN should take charge of the code. The Medical Director stated he would rather the staff initiate CPR, then verify the code status, and then stop CPR if it was determined the resident had a DNR order.it ' s a tricky slope. If you wait too long [delay in performing CPR] .3 minutes brain damage . The Medical Director stated there should not be a delay in performing CPR waiting on staff to verify a code status. If you don't start CPR right away then you loose ,d+[DATE] minutes .valuable minutes . Let's say go ahead and start CPR .if wait to get the book [code book which contains the residents' POST forms] then you've lost that time .But, if [staff] start CPR on someone [a resident] who is a DNR then .run the risk of running into the same problem again [performing CPR on a resident who has DNR code status, which occurred on [DATE] with Resident #3] .This [code status, code verification implementation] is something we [the Medical Director and the facility's administrative staff] will need to discuss with the DON and the nursing staff .It ' s a tricky situation . The Medical Director confirmed only CPR trained staff should perform CPR and was not aware untrained, non-CPR certified staff had performed CPR. The Medical Director stated he understood the residents' wishes needed to followed, and stated .it is so rare for CPR to bring this population back it's like , d+[DATE]%. We need to follow orders and wishes but can't waste time before starting .We will need to discuss this in QAPI . The Medical D [TRUNCATED]

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39794 Based on facility policy review, job description review, medical record review, employee time punch review, and interview, the facility failed to provide competent and proficient nursing staff to assure resident safety an attain or maintain the highest practicable level of wellbeing of residents when nursing staff failed to honor the end of life wishes, failed to ensure nursing staff were knowledgeable of a code status, met specific competency requirements, and understood their job responsibilities related to Cardio-Pulmonary Resuscitation (CPR), Do Not Resuscitate (DNR) Status, and life saving measures for 4 of 5 residents (Resident #3, #8, #9, and #10) reviewed for CPR. The facility's non-compliance placed Residents #3, #8, #9, and #10 in Immediate Jeopardy (IJ) (A situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) when CPR was performed against Resident #3's wishes, when untrained, non-CPR certified staff performed CPR on 3 residents (Residents #8, #9, and #10), and when untrained, non-CPR certified, staff expressed an intent to perform CPR in the event of a cardiac or respirator arrest of a resident, which had the potential or likelihood to affect all residents of the facility. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy at F-726 on [DATE] at 3:30 PM. The facility was cited Immediate Jeopardy at F-726 at a scope and severity of K. The facility was cited Immediate Jeopardy at F-678 which constituted substandard quality of care. The facility was cited Immediate Jeopardy at F-835, F-837, and F-867 at a scope and severity of K. A partial extended survey was conducted onsite from [DATE] through [DATE]. An acceptable Removal Plan which removed the immediacy was provided by the facility on [DATE] at 8:35 PM for F-726. The IJ began on [DATE] and continued through [DATE]. The IJ ended on [DATE] and was removed on site. The corrective actions were validated on site by the surveyor on [DATE] for F-726. Noncompliance continued at F-726 at a scope and severity of E. The facility is required to submit a Plan of Correction. The findings include: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled, Cardiopulmonary Resuscitation (CPR), dated ,d+[DATE], revealed .If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency services .in accordance with the resident's advance directives .Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills . Review of the facility job description of a Certified Nursing Assistant (CNA) dated [DATE], revealed . POSITION SUMMARY: The primary purpose of your job position is to provide each of your assigned residents .services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors .Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors .Perform special treatment as instructed .Inform the nurse Supervisor/Charge Nurse of any changes in the resident's condition so that appropriate information can be entered on the resident's care plan . Review of a job description for the Executive Director/Administrator, signed and dated [DATE], revealed . POSITION SUMMARY: Directs day-to-day operations of a skilled nursing facility in accordance with current, federal, state, and local laws, regulations and guidelines .ESSENTIAL DUTIES AND RESPONSIBILITIES . Ensures delivery of quality skilled nursing .services to residents . Review of a job description for the Director of Nursing (DON), signed and dated [DATE], revealed . POSITION SUMMARY: To assist in the management and direction of the Nursing Department in accordance with federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and Medical Director, to ensure that the highest degree of quality care is maintained at all times. As the Director of Nursing, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .ESSENTIAL DUTIES AND RESPONSIBILITIES .Manages and directs all aspects of the Nursing Services Department . Ensures that new nursing staff are properly oriented and trained . 1. The facility failed to verify a code status on the POST form, before performing CPR on Resident #3 on [DATE]. Resident #3's order for a full code status (CPR) was not changed in the electronic medical record (EMR)to reflect a new DNR code status order resulting in Resident #3 receiving CPR against the resident's wishes. 1a. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Chronic Congestive Heart Failure, Muscle Weakness, Diabetes Mellitus, and Systemic Lupus Erythematosus. Review of a Physician's order for Resident #3 dated [DATE], revealed CPR/Full Code. Review of the Tennessee Physician Orders for Scope of Treatment (POST) form dated [DATE], revealed Resident #3 selected DNR no CPR and to allow natural death. The POST form was signed and dated by the Physician on [DATE]. Review of a facility document titled, CPR/Code Blue Documentation, dated [DATE], revealed Resident #3 was discovered unresponsive in the dining room at 1:20 PM. The staff initiated CPR at 1:21 PM. CPR was paused at 1:38 PM with return of respirations. The document revealed the resident's son returned a call to the facility at 1:42 PM and wanted to continue Resident #3's DNR status as the resident had requested and did not want the resident sent to the hospital. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility investigation for Resident #3 dated [DATE], revealed the facility conducted a Quality Assurance Performance Improvement (QAPI) meeting, and determined the Root Cause Analysis (RCA) for the event was the failure of staff not entering the new physician's orders from the POST form for a DNR status dated [DATE], in the EMR. During an interview on [DATE] at 10:00 AM, Registered Nurse (RN) F revealed she was in the conference room when she heard the code blue called (indicating the need for CPR) to Resident #3's room. Continued interview revealed RN F told Licensed Practical Nurse (LPN) D she would continue the chest compressions and RN G continued with the respirations. Further interview confirmed they paused with the 2nd round of CPR to check for a pulse and respirations and observed Resident #3 was breathing on her own, had a weak pulse, and CPR was stopped. During an interview on [DATE] at 10:15 AM, RN G revealed the Housekeeper stepped out of the dining room and asked for help for Resident #3. RN A checked the EMR and stated Resident #3 was a full code. Further interview revealed RN G called 911 for assistance, LPN D began chest compressions, and RN G initiated respirations with the ambu bag (a manual medical device used to force air into the lungs in emergent situations when someone is not breathing or having difficulty in breathing). During an interview on [DATE] at 10:30 AM, the Assistant Director of Nursing (ADON) stated she reported to Resident #3's family what had occurred (the facility had performed CPR on Resident #3 against her wishes), and since Resident #3 had chosen to have a DNR status and did not want CPR performed, the family did not want the resident transferred to the hospital after the event. During an interview on [DATE] at 10:40 AM, the Social Services Director (SSD) stated she was on duty and heard the code blue called for Resident #3. The SSD stated she printed out the paperwork, which included Resident #3's POST form for Emergency Medical Services (EMS), and realized Resident #3 had requested not to have CPR and had a DNR code status. The SSD stated she immediately took it to Resident #3's room and notified the nursing staff of the DNR status. Further interview revealed the nurses had already stopped CPR because the resident had resumed breathing and had a pulse. During an interview on [DATE] at 11:00 AM, the Medical Records Director stated she was responsible for obtaining a signature from the Physician on a POST form, she scanned the POST form into the EMR, then gave the form to the nurse to enter the order in the EMR. The Medical Records Director stated the facility's process was not followed and the order for Resident #3's code status was not changed from a Full code status to a DNR code status on [DATE]. During an interview on [DATE] at 11:15 AM, the Admissions Director confirmed she had spoken with Resident #3 on [DATE] and completed the POST form at which time the resident indicated she did not want CPR to be performed if she had no pulse and no respirations. Continued interview revealed she had given the form to the Medical Records Director to obtain the Physician's signature. During an interview on [DATE] at 11:15 AM, LPN D revealed RN A announced Resident #3 was a full code and started chest compressions. LPN D stated RN G initiated respirations with the ambu bag, and after RN F entered the room, she took over the chest compressions. During an interview on [DATE] at 2:13 PM, the DON stated it was her expectation for residents found unresponsive for Registered or Licensed nursing staff to verify the resident's code status before performing CPR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri State Health and Rehabilitation Center	600 Shawanee Rd Harrogate, TN 37752

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. The facility failed to identify staff were not appropriately trained, knowledgeable, were certified in CPR, and had the competencies to perform CPR after performing CPR on Resident #8 on [DATE], Resident # 9 on [DATE], and on Resident #10 on [DATE]. Review of employee's online training record transcript and personnel files on [DATE], and [DATE], revealed CNA A, CNA C, CNA G, and CNA N did not have a current CPR certification. 2a. CNA N, who was not certified in CPR, performed CPR on Resident #8 on [DATE]. Review of a POST form for Resident #8 dated [DATE] (from previous admission to the facility), revealed Resident #8 requested CPR and full treatment. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic Respiratory Failure with Hypoxia, Dysphagia, Cognitive Communication Deficit, Chronic Obstructive Pulmonary Disease, Diabetes, Obstructive Sleep Apnea, Bipolar Disorder, Atrial Fibrillation, and a history of Stroke. Review of a Physician's order for Resident #8 dated [DATE], revealed the resident had an order for CPR/Full Code. Review of a nurse's note for Resident #8 dated [DATE], revealed Resident #8 was found unresponsive at 5:55 AM. The resident did not have a heart rate or respirations. Chest compressions were started, Emergency Medical Services (EMS) and the Hospital were notified. EMS arrived at to the facility at 6:11 AM. EMS pronounced Resident #8 deceased at 6:32 AM. Review of a facility document for Resident #8 titled, CPR/Code Blue Documentation, dated [DATE], revealed the document was completed by LPN H. The event (cardiac arrest situation for Resident #8) which occurred at 5:55 AM was unwitnessed. EMS was called at 5:55 AM and arrived at the facility at 6:11 AM. The document noted RN D and LPN H participated in the code. Resident #8 was pronounced deceased at 6:32 AM. Review of the facility staff time punches dated [DATE], revealed RN D, RN E, LPN D, CNA K, and CNA N were on duty at the time of the code situation for Resident #8. During an interview on [DATE] at 4:39 PM, RN D stated on [DATE] Resident #8 was found unresponsive at shift change. RN D stated CNA K and CNA N assisted with the code but could not recall who had initiated CPR. RN D stated he verified Resident #8 was a full code and either RN D or LPN H advised the staff Resident #8 was a full code and to Continue the code. RN D stated CNA N (CNA N was not CPR certified) assisted with the chest compressions until EMS arrived. During a telephone interview on [DATE] at 5:05 PM, CNA K stated she participated in Resident #8's code on [DATE]. CNA K stated she was advised by the previous shift staff Resident #8 was found unresponsive and a code blue was called. CNA K stated she and CNA M .grabbed the crash cart [located in the break room] and went to the room [Resident #8's room] . CNA K stated CPR was initiated by RN E and after a few minutes, she took over chest compressions from RN E. CNA K stated CNA N (CNA N was not CPR certified) also took turns with the ambu bag and chest compressions until EMS arrived. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 5:35 PM, CNA N stated there was a code with a male resident a few months ago (was unable to recall the resident ' s name or date, later determined it was Resident #8). CNA N stated .I did put my hands on him, they [unable to recall the staff who requested assistance] asked me to .I don ' t really remember the situation. I left after the ambulance came . CNA N stated she was not trained or certified in CPR and further stated she was aware CPR was only to be performed by trained staff. CNA N stated .I only had my hands on him a few minutes just to help out .the other people in the room did most of it . 2b. CNA A and CNA G, who were not CPR certified, performed CPR on Resident #9 on [DATE]. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Dysphagia (Difficulty Swallowing), Cerebral Infarction (Stroke), Protein Calorie Malnutrition, Diabetes, Anemia, Dementia, Chronic Kidney Disease Stage 2, and Chronic Obstructive Pulmonary Disease. Review of a POST form for Resident #9 dated [DATE], revealed the resident requested CPR and full treatment. Review of a physician's order for Resident #9 dated [DATE], revealed the resident had a full code status (CPR). Review of the facility document for Resident #9 titled, CPR/Code Blue Documentation, dated [DATE], revealed the form was completed by LPN E. The event (cardiac arrest situation for Resident #9) which occurred at 4:15 AM was unwitnessed. EMS was called at 4:15 AM and arrived at the facility at 4:50 AM. The document noted LPN E and LPN G participated in the code. Resident #9 was pronounced deceased at 4:50 AM. Review of a nurse's note for Resident #9 dated [DATE] at 5:43 AM, revealed at 4:15 AM Resident #9 was observed with no visible signs of life and no vital signs. CPR was initiated and EMS notified. EMS arrived at the facility at 4:25 AM and pronounced Resident #9's death at 4:50 AM. Review of the facility time punches dated [DATE], revealed LPN E, LPN G, CNA A, and CNA G were on duty at the time of the code situation for Resident #9. During an interview on [DATE] at 9:00 PM, CNA A stated he was not CPR certified. CNA A stated if a resident was observed without a heart rate and no respirations, he would call for help and immediately start CPR until a nurse or other staff took over. CNA A stated if the nursing staff advised that the resident had a DNR status, then CPR would be stopped, immediately. CNA A stated he had participated in a Code Blue situation with Resident #9 .a few weeks ago . CNA A stated he started chest compressions and assisted with the code until the paramedics arrived.I remember because he was frail and we crushed his ribs .you could feel it and hear it .[fractured ribs were unable to be determined] . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:30 PM, CNA G stated he was unsure if his CPR certification had expired .but I think so . CNA G stated if he observed a resident without a heartbeat or was not breathing, he yelled Code Blue and initiated CPR until other staff arrived with the crash cart. CNA G stated the staff usually initiated CPR and if the nurse notified the staff that a resident was a DNR, then CPR would be immediately stopped. CNA G stated he had participated in several codes in the past few months at the facility but was unable to recall exact dates or names of residents. CNA G stated the last code he participated in was a male resident that happened about a month ago (later determined it was Resident #9) and he and another nurse (LPN G) initiated CPR. CNA G stated CNA A also assisted with chest compression to help relieve staff. LPN E went to check Resident #9's code status, came back to the resident's room, stated Resident #9 was a full code, and CPR was continued until EMS arrived. CNA G stated he performed chest compressions and knew how to perform CPR due to being previously CPR certified (date of last certification was unknown). During a telephone interview on [DATE] at 4:04 PM, LPN G stated on [DATE], Resident #9 was found unresponsive by CNA A. LPN G stated she and CNA G went to Resident #9's room and proceeded to code him (perform CPR). (CNA G was not trained or CPR certified).I knew he [Resident #9] was a full code. LPN G stated CNA G and CNA A relieved her and assisted with chest compressions until LPN E arrived to help. LPN G stated LPN E, LPN I, CNA A, and CNA G assisted in performing CPR with chest compressions or the ambu bag until EMS arrived to take over the code. LPN G stated EMS pronounced Resident #9 ' s death at 4:50 AM. 2c. CNA C, who was not CPR certified, performed CPR on Resident #10 on [DATE]. Review of a POST form for Resident #10 dated [DATE], revealed the resident requested CPR and full treatment. The physician signed the POST form on [DATE]. Review of a Physician's Order Summary Report for Resident #10 dated [DATE] (3 days prior to admission, order obtained from the POST form) revealed the resident had a CPR/full code status. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Diabetes, Severe Protein-Calorie Malnutrition, Dementia with Psychotic Disturbance, and Major Depressive Disorder. Review of a nurse's note for Resident #10 dated [DATE], revealed the resident was noted to be unresponsive and without a pulse. CPR was initiated at 4:05 PM and EMS was notified. Resident #10 was transferred out of the facility by EMS at 4:40 PM. Review of a facility document for Resident #10 titled, CPR/Code Blue Documentation, dated [DATE], revealed the document was completed by RN E. The event (cardiac arrest situation for Resident #10) which occurred at 4:00 PM was unwitnessed. EMS was called at 4:00 PM and arrived at the facility at 4:40 PM. The document noted RN E performed CPR. Resident #10 was transferred to hospital via (by way of) air support and expired at the hospital at 5:59 PM on [DATE]. Review of a nurse's note for Resident #10 dated [DATE] at 6:30 PM, revealed the hospital called the facility and notified the staff Resident #10 had passed away at the hospital. Review of the facility time punches dated [DATE], revealed RN E, CNA C, and CNA O were on duty at the time of the code situation for Resident #10. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 9:38 PM, CNA C stated approximately 2 weeks ago (actual date was [DATE]) Resident #10 was found with no pulse, the nurse was notified, and CPR was initiated. CNA C (CNA C was not CPR certified) stated she performed CPR until another nurse verified the code status and was told CPR was to be continued. During an interview on [DATE] at 10:48, LPN D stated she was CPR certified and had participated in a code with Resident #10 approximately ,d+[DATE] weeks ago. LPN D stated Resident #10 went into a cardiac arrest, and CPR was initiated. LPN D stated, .I thought I remembered him [Resident #10] being a Full Code . so we [LPN D and CNA C] [CNA C was not trained and not CPR certified] went ahead and started CPR . LPN D stated another staff member (could not remember the name) did verify on the EMR, Resident #10 . was a full code and so we continued CPR until EMS arrived .I know if you start CPR on someone who is a DNR you are going to be in trouble .that happened here before .so I am glad he was a full code when the other nurse checked .but I thought I remembered him being a full code . During a telephone interview on [DATE] at 4:19 PM, RN E stated one of the CNAs said Resident #10 was not responding and did not know his code status. RN E stated Resident #10's code status was checked by the resident's primary nurse, LPN D, who was at the nurse ' s station. RN E stated it was unknown who initiated CPR on Resident #10. RN E stated 911 was called and after EMS arrived, she went to Resident #10's room. RN E stated CNA C and CNA O helped with the ambu bag but was unsure if they performed chest compressions. RN E stated EMS .worked on him [CPR] for ,d+[DATE] minutes and they were going to pronounce him .the ER doctor said to pronounce him .and then they went to unhook him [remove monitors and Automatic External Defibrillator [AED] and he [Resident #10] started breathing . RN E stated the resident was transferred by life flight to the hospital. RN E stated the facility received a call from the hospital a short time after the resident was transported and was advised the resident had expired. During a telephone interview on [DATE] at 4:34 PM, CNA C stated on [DATE], another CNA found Resident #10 unresponsive and .she went and got the room ready and me [CNA C] and another CNA [CNA O] got the crash cart out of the break room and took it down to his [Resident #10's] room .One of the nurse's started CPR but I don ' t know their name .I [CNA C] think I am CPR certified [CNA C was not trained or CPR certified] or I think I was and I helped them .I relieved one of the nurse's and did chest compressions on him [Resident #10] until the ambulance got here .I can ' t remember if he was taken out or pronounced here . (The date CNA C was last certified in CPR was unknown). During review of employee's online training record transcript, personnel files, and CPR certifications, and interview on [DATE] at 5:30 PM, the DON confirmed CNA A, CNA C, CNA G, CNA N, and CNA O were not CPR certified. During a telephone interview on [DATE] at 9:33 PM, CNA O stated she was not CPR certified and had participated in codes when the staff needed help. CNA O stated she was unable to recall the last code she had participated in and could not recall the resident ' s name. During interviews with staff during the survey, it was determined CNA O participated in CPR for Resident #10 on [DATE]. The facility failed to ensure facility staff were knowledgeable and had the competencies to perform CPR when untrained staff expressed an intent to perform CPR should the need arise. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 39794 Based on facility policy review, job description review, facility document review, Quality Assurance and Performance Improvement (QAPI) Plan review, QAPI Meeting Minutes review, and interviews, the facility's Administration failed to provide effective leadership and oversight after 1 resident's (Resident #3) end of life wishes were not honored and 4 staff members who were not trained or certified in Cardio-Pulmonary Resuscitation (CPR) and life sustaining measures performed CPR on 3 residents (Residents #8, #9, and #10) from ,d+[DATE]-,d+[DATE] of 5 residents reviewed for CPR. The facility's Administration failed to identify the non-compliance and develop and implement effective processes through the facility's Quality Assurance and Performance Improvement (QAPI) committee. Administration failed to ensure the effective training of staff after identifying CPR was performed on 1 resident (Resident #3) against the resident Physician's Order for Scope of Treatment (POST) for a Do Not Resuscitate (DNR) code status, failed to identify that non-CPR certified and untrained staff performed CPR on 3 residents from ,d+[DATE]-,d+[DATE], and failed to identify, educate, and put action steps in place when Certified Nursing Assistants (CNAs) and Housekeeping Staff, who were not CPR certified, expressed an intent to perform CPR without having the adequate training or certification, in the event of cardiac or respiratory arrest of a resident. The Administration's failure to provide effective oversight and leadership resulted in an Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) for Residents #3, #8, #9, and #10 and had the potential or likelihood to impact all residents of the facility. The Administrator and the Director of Nursing Services (DON) were notified of the Immediate Jeopardy (IJ) for F-835 on ,d+[DATE] at 3:30 PM, in the conference room. The facility was cited Immediate Jeopardy at F-835 at a scope and severity of K. The facility was cited Immediate Jeopardy at F-678 at a scope and severity of K which constitutes standard quality of care. The facility was cited Immediate Jeopardy at F-726, F-837, and F-867, at a scope and severity of K. A partial Extended Survey was conducted onsite from [DATE] through [DATE]. The IJ began on [DATE] and continued through [DATE]. The IJ ended on [DATE] and was removed on site. An acceptable Removal Plan which removed the immediacy was provided by the facility on [DATE] at 9:48 PM for F-835. The corrective actions were validated on site by the surveyor on [DATE] for F-835. Noncompliance continues at F-835 at a scope and severity of E. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility is required to submit a Plan of Correction (POC). The findings include: Review of a facility policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated , d+[DATE], 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 .The objectives of the QAPI Plan are to .Provide a means to identify and resolve present and potential negative outcomes related to resident care and services .The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements .The QAPI Committee, Administrator, and the governing board shall review and approve a summary of problems and corrective measures . Review of a job description for the Executive Director/Administrator dated [DATE], revealed .POSITION SUMMARY: Directs day-to-day operations of a skilled nursing facility in accordance with current, federal, state, and local laws, regulations and guidelines .ESSENTIAL DUTIES AND RESPONSIBILITIES .Directs the day-to-day operations of a skilled nursing facility .Ensures delivery of quality skilled nursing .services to residents .Employs and supervises competent and qualified department managers .Makes reports/recommendations to the facility's governing body .Serves on facility committees .Quality Assurance & Assessment .Other Specific Requirements .Thorough knowledge of federal, state and local laws regulations and guidelines that pertain to skilled nursing facilities .Must be knowledgeable of nursing and medical practices and procedures, as well as laws regulations and guidelines that pertain to long-term care . Review of a job description for the Director of Nursing (DON), dated [DATE], revealed .POSITION SUMMARY: To assist in the management and direction of the Nursing Department in accordance with federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and Medical Director, to ensure that the highest degree of quality care is maintained at all times. As the Director of Nursing, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .ESSENTIAL DUTIES AND RESPONSIBILITIES .Manages and directs all aspects of the Nursing Services Department .Makes rounds to ensure that nursing personnel perform their work assignments in accordance with acceptable nursing standards .Reviews nursing personnel medical record documentation to ensure that it is appropriately and accurately descriptive of the nursing care provided .Supports the Quality Assessment & [and] Assurance Committee in developing and implementing appropriate plans of action to correct identified deficiencies . Serves on facility committees .Quality Assessment and Assurance .Ensures that new nursing staff are properly oriented and trained .Develops, plans and conducts in-service training classes .Develop a written plan of care .for each resident that identified the problems/needs of the resident, indicates the care to be given, goals to be accomplished .Other Specific Requirements .Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long-term care . Review of an undated, unsigned facility document revealed .Governing body notification to .Clinical Resource and .Market Leader on [DATE] by [Administrator/DON] by phone after our QAPI meeting . The facility's governing body included the Administrator, Clinical Resource, and Market Leader. Further review of the document revealed the last annual governing body meeting was held on [DATE]. The document did not note the current performance improvement plans or an agenda. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	09/26/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility document (attached to the undated and unsigned facility Governing body notification for the date [DATE] annual meeting) titled, QAPI [DATE] Meeting Minutes, revealed the document was a sign in sheet and was dated [DATE] (and not [DATE] as indicated on the attached document). The documents were provided by the Administrator, as part of the Governing Body meeting minutes. A second attached document was dated [DATE] (and not [DATE] as noted on the unsigned and undated Governing body notification or the [DATE] Meeting Minutes sign in sheet). The second attached document revealed the document was meeting minutes and noted the staff in attendance included the Administrator and the DON. The agenda of the [DATE] meeting did not address POST forms, Advanced Directives, or CPR. The document revealed Code Blue (an announced code to alert staff of a cardiac or respiratory arrest and need for CPR) drills were reviewed as part of a Life Safety Review with no additional information related to the drills. Review of the facility document titled, QAPI ADHAWK [Ad Hoc] Meeting (held for a particular purpose when necessary) Minutes, dated [DATE], revealed the Administrator, DON, Social Services Director (SSD), and Medical Director attended the meeting. The attached meeting document titled, Ad Hawk [Ad Hoc] QAPI today [DATE] regarding Post [POST] Form Review, revealed the event that occurred with Resident #3 when the resident went into cardiac arrest, the staff performed CPR against the resident ' s wishes on [DATE] was discussed. A root cause analysis was conducted, and it was determined when the POST form was scanned into the miscellaneous section of the of the electronic medical record (EMR) the order was not changed and the Medication Administration Record (MAR) within [EMR] continued to reflect Resident #3 was a full code and CPR was to be performed. The meeting minutes revealed education was given to the Medical Records Manager, that moving forward she will be giving all POST forms directly to the DON or designee to ensure orders in the EMR matched the scanned POST form. Further review revealed no documentation related to the facility's code book (book which contained residents' POST forms to indicate code status) and no documentation to reflect all nursing staff had been educated or in-serviced on the new process for POST forms and code book. Review of a facility document titled, Education for Medical Records/Admissions Post Forms, dated [DATE], revealed .To ensure POST FORMS match the respective advance directive order we are implementing a new procedure. After admissions reviews and completes a POST FORM with family it will be uploaded in the chart [EMR] under' Admission Agreement' along with other required documents. Medical Records ensure POST FORMS are signed promptly, and upon physician signature, will review with DON or designee to ensure the order and physical form are synonymous and correct . Continued review revealed the document was signed by the Administrator, the DON, the Admission Director, the Medical Records Director, and the Licensed Practical Nurse (LPN) Case Manager. Review of a facility document titled, In-service Attendance Record .Course Title: Enhanced Barrier Precautions [EBP], dated [DATE], revealed handwritten on the document Round [NAME]. Continued review revealed 3 Registered Nurses (RNs), 2 LPNs, and 13 Certified Nursing Assistants (CNAs) signed they had received the in-service on EBP Precautions and Round [NAME]. A second attached sign-in sheet also dated [DATE] indicated an in-service was provided on EBP and Round [NAME] to an additional 22 CNAs, and 3 LPNs. Further review revealed the specific education was not attached to the sign-in sheet to reflect what was discussed during the round [NAME] meeting. There was no documentation attached to the In-Service Attendance Record that all staff were educated on POST forms, code status, the Code Book, and checking the code status before proceeding with CPR. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a QAPI Committee Meeting dated [DATE], revealed the Administrator and the DON attended the meeting. The minutes revealed no documentation related to the facility's code book, or that non-CPR certified staff intended to perform or did perform CPR. Further review revealed no documentation that all nursing staff had been educated or in-serviced on the new process of the POST forms and code book. Review of the QAPI Committee Meeting dated ,d+[DATE]-,d+[DATE], revealed the Administrator, the DON, and the Medical Director attended the meeting. The QAPI minutes revealed the old business discussed was of the POST form audit from the ongoing PIP. Continued review revealed no documentation that all nursing staff had been educated or in-serviced on the new process of the POST forms, the code book, or that non-CPR certified staff intended to perform or did perform CPR. Review of the QAPI Committee Meeting dated [DATE], revealed the Administrator, the DON, and the Medical Director attended the meeting. Continued review revealed no documentation that all nursing staff had been educated or in-serviced on the new process of the POST forms, the code book, or that non-CPR certified staff intended to perform or did perform CPR. During an interview on [DATE] at 10:18 PM, the ADON stated in-services and round [NAME] meetings were held with nurses and CNA's weekly to keep staff updated on any issues and the meetings allowed staff to address any concerns they may have. The ADON stated on [DATE] all staff on duty that day were educated on POST forms, code status', the Code Book, and checking the code status before proceeding with CPR. The ADON stated the Code Book had always been located at the nurse's station and was not a new process. The ADON stated all staff were educated through the round [NAME] meetings. The ADON stated it was her expectation CPR not to be initiated until the resident's code status was verified. During interviews with multiple staff from [DATE]-[DATE], revealed 14 CNAs were not aware of the code book, the contents, or the exact location of the book. 1 Housekeeper was not aware of the code book or its contents, 1 CNA was not aware of where to locate the crash cart, 4 LPNs and 1 RN stated they would not use the code book because they were not sure when or who updated the code book and was unsure of its accuracy. 5 CNAs and 1 housekeeper stated they would perform CPR if a resident was found unresponsive, not breathing, and no heartbeat even though they were not certified in CPR, and 4 CNA's performed or assisted with CPR either with chest compressions or rescue breathing with an ambu bag who were not CPR certified from ,d+[DATE]-,d+[DATE] for 3 residents. The facility's Administration failed to identify non-compliance related to CPR/DNR or code status protocols, failed to ensure staff were educated related to the code book its contents or location and accuracy, code status protocols, performing CPR without being CPR certified, or the likelihood of staff performing CPR when not CPR certified. The facility's Administration failed to maintain effective oversight and leadership to identify quality deficiencies, put action steps in place, and to have an effective QAPI program to prevent or address patterns of non-compliance. During an interview on [DATE] at 2:13 PM, the DON stated it was her expectation that all staff who perform CPR be CPR certified. The DON further stated she had not been made aware untrained staff had performed CPR and was not aware untrained, non-CPR certified staff expressed the intent to perform CPR. The DON stated the licensed nursing staff were educated on the new POST process and code book after the [DATE] incident with Resident #3 and was unsure why the staff had indicated they had not received the in-service. (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Since code status is applicable to all residents, Medical Records, under the direction of the Administrator, audited all residents' POST forms (or absence thereof) and verified that the Physicians' Orders in the EMR matched what was on the POST forms. This audit was completed on [DATE]. No discrepancies were identified during the audit. Ad hoc QAPI meeting held at 4:00pm on [DATE]. Purpose to discuss and review all IJ templates and removal plan. Members present Medical Director, Administrator, DON, Governing Body, RN Charge nurse, ADON, and MDS nurse. QAPI meetings on [DATE] and [DATE] resulted in the following: -On [DATE] the Code Blue binder changed to a bright blue binder to ensure staff would recognize during code blue event. - On [DATE] the education discussed above, all employees who received education have been provided with a small quick reference card labeled Code Blue that they will attach to the back of their name badge which says: Unresponsive = Call for help; Do not do CPR if not certified; Code book at nurses station; Crash cart in break room; Clear hallway; and Assist EMS to location. Any employees/new hires that haven't received the education and cards will be provided before their next shift by DON (or designee). -CPR Code Blue questionnaire created on [DATE], and the CPR policy was revised during ad hoc QAPI on [DATE] and will be followed. Employees on duty [DATE] after 6:00 PM were in-serviced on the revised policy. The facility will arrange for an outside CPR Certification Course provider to hold a CPR Certification Course for all interested employees at least 4 times per year. Facility will ensure that CPR certified staff will be available at all times. HR staff (or designee) will verify CPR certification and obtain a copy of current CPR certification card for all new hires. HR staff (or designee) will maintain a list of CPR certified employees by expiration month. Medical Records audited all residents' POST forms on [DATE] and found them up to date and all matching. Medical Records will perform POST form audits at least monthly and verify that the Physician's Order in the EMR matches the POST form. The Clinical Interdisciplinary Team (IDT) (DON, Assistant Director of Nursing (ADON), Minimum Data Set (MDS) Coordinator, Social Services Director) will audit any new or revised POST forms during clinical meeting daily Monday-Friday. Any issues will be immediately brought to the DON (or designee) for correction. Audit results will be brought by the DON (or designee) to the QAPI Committee (MD, DON, Administrator, Social Services, MDS, RN Supervisor, Infection Control RN, Environmental Services (EVS) supervisor, CDM, Maintenance) at the next meeting and moving forward. QAPI committee to provide additional recommendations as necessary. Following each code blue incident, DON and Administrator (or their designees) will review the event the next business day during morning meeting with the IDT to verify: (1) that advanced directives were followed, and if CPR was performed that (2) the RN Charge Nurse documented the names of the individuals who performed CPR on the Code Blue Checklist and (3) it was performed by CPR certified individuals. Administrator (or designee) will arrange ad hoc QAPI meeting the same day to respond to any instances of noncompliance. (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During regular QAPI meetings, the committee will also review all code blue events since the last meeting and verify CPR was not initiated for anyone with Advance Directive documentation for DNR, and to verify CPR was only performed by individuals with CPR certification. The QAPI committee will provide additional recommendations as needed. All employees who are members of the QAPI committee received the above training on [DATE], or if not present as of 10:00 AM, they will receive the training on their next scheduled workday. On [DATE] the Administrator interviewed a sample of 8 employees on CPR policies. Administrator (or designee) will interview 10 random employees weekly to include day, night, and weekend shifts for the next month, and then monthly thereafter. The administrator asked the following questions: In the event a resident appears to need CPR, who can perform CPR? If you are helping respond to a code blue incident, how can you help verify a resident ' s code status? On [DATE] the Administrator interviewed 3 licensed charge nurses on the Code Blue Checklist/Documentation. Administrator (or Designee) will continue interviewing 3 Licensed Charge Nurses weekly for the next month. The question included is What form do you fill out during a code blue event? (Code Blue Checklist/Documentation attached for review) If needed, additional training will be provided by DON (or designee) based on responses to the above interviews. Governing Body Representatives (Operations Resource and Clinical Resource) provided education remotely and in person to the Administrator and Director of Nurses on [DATE] regarding all the above. Beginning on [DATE] A Governing Body Representative will review all code blue checklists and sign the code blue checklist form confirming review. All Code Blue events will be reviewed during each QAPI meeting and placed on the agenda. Results of the employee interviews referenced above, will be reviewed by a member of the Governing Body with the Administrator at least weekly for the next 3 months. A member of the Governing Body will review QAPI minutes related to code blue events and effectiveness of the above interventions following each of the next 3 meetings, and then at least quarterly thereafter. The Governing Body will provide additional education and training as necessary based on findings, interviews, and review of QAPI minutes. Surveyor verified and validated the removal plan for F-867, dated [DATE] as follows: Surveyor reviewed facility documentation of a CPR Training sign-up sheet for all staff. The training will be in , d+[DATE]. The CPR Training sign-up sheet was located on the break room door and the break room. Surveyor reviewed a Mock Code Evaluation Checklist dated [DATE] at 9:50 PM and revealed 5 CNAs and 1 LPN participated with no issues identified. The check list included the names of participants, the time of actions, notifications, and status of resident. Surveyor reviewed a Mock Code Evaluation Checklist dated [DATE] at 9:55 PM and revealed no issues. Surveyor reviewed the revised CPR policy dated [DATE] with changes related to adding CPR classes 4 times per year and only CPR certified staff will participate in CPR. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor reviewed and validated the revised CPR policy was signed by 125 employees of the facility. Those on leave/vacation will sign upon their return. Surveyor reviewed a POST form audit on all residents conducted on [DATE] with 100% Compliance. Surveyor selected a random selection of 20 residents for the code status on the POST form matched the physician's orders and the electronic medical record with no issues or concerns identified. Surveyor reviewed an in-service training related to the Code Blue Checklist dated [DATE]. The education conducted by the ADON revealed 12 nursing staff received the education. Those not on duty/leave will be educated upon their return to work. Surveyor conducted interviews on [DATE] with 4 RNs, 7 LPNs, the DON, and the Administrator who confirmed understanding of the Code Blue Checklist. Surveyor verified by observation the Code Blue Checklist was located on the crash cart in the breakroom. Surveyor reviewed a QAPI sign in sheet dated [DATE] and revealed the required parties attended the meeting and the following was discussed: Immediate Jeopardy templates of F678, F835, F837, F867, and F726. Action steps with assigned responsible staff were included. Surveyor reviewed in-service education and sign-in sheets regarding POST forms conducted on [DATE] with 17 staff members. On [DATE], Surveyor interviewed 5 Housekeeping/Laundry Staff, 13 CNAs, 4 RNs, 7 LPNs, the Environmental Services Director, Social Services Director, Licensed Clinical Social Worker, the Maintenance Director, the Medical Records Director, the ADON, the DON, and the Administrator and all staff were able to verify they had received the education and the process and steps when POST forms were received or changed. Surveyor reviewed a CPR/Code Blue Questionnaire which revealed 125 employees received the questionnaire on ,d+[DATE] or [DATE] by the Administrative staff. Surveyor verified the questionnaires were completed and documented by the 125 employees. CNA questionnaire included: What would you do if you found a resident that is not responsive? What is your role during a code blue? Can you do CPR if you are NOT currently certified? Are you currently CPR certified? RN questionnaires completed which include: What form do you fill out during a code blue event? The answer Code Blue Checklist. 3 RNs were questioned by the Administrator. The Administrator questioned a sample of employees of 8 on [DATE] regarding the following: In the event a resident appears to need CPR, who can perform? (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39794 Based on facility documentation review, facility policy review, job description review, and interview, the facility's Governing Body failed to identify non-compliance and implement effective corrective action plans through the facility's Quality Assurance and Performance Improvement (QAPI) program, failed to provide effective leadership and oversight to the facility and the facility's administration to ensure all nursing staff, including Certified Nursing Assistants (CNAs), were educated on the code or Cardiopulmonary Resuscitation (CPR) process when Resident #3's end of life wishes for Do Not Resuscitate (DNR) were not honored on [DATE], when CPR was performed on 3 residents (Residents #8, #9, and #10) from [DATE] through [DATE] by 4 CNAs who were not trained or certified in CPR life sustaining measures, and when the facility failed to identify, educate, and put action steps in place when CNAs and Housekeeping Staff, who were not CPR certified, expressed an intent to perform CPR without having the adequate training in the event of cardiac or respiratory arrest of a resident. The Governing Body's failure to provide adequate leadership to oversee and maintain safe CPR practices by qualified, trained, and educated staff, had the potential or likelihood to impact all the residents in the facility, which placed the residents in Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy at F-837 on [DATE] at 3:30 PM. The facility was cited Immediate Jeopardy at F-837 at a scope and severity of K. The facility was cited Immediate Jeopardy at F-678 at a scope and severity of K which constituted substandard quality of care. The facility was cited Immediate Jeopardy at F-726, F-835, and F-867 at a scope and severity of K. A partial extended survey was conducted onsite from [DATE] through [DATE]. An acceptable Removal Plan which removed the immediacy was provided by the facility on [DATE] at 9:48 PM for F-837. The IJ began on [DATE] and continued through [DATE]. The IJ ended on [DATE] and was removed on site. The corrective actions were validated on site by the surveyor on [DATE] for F-837. Noncompliance continued at F-837 at a scope and severity of E. The facility is required to submit a Plan of Correction. The findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri State Health and Rehabilitation Center	600 Shawanee Rd Harrogate, TN 37752

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Review of an undated, facility document titled, Governing Board, revealed .The governing board is the corporate entity or licensee responsible for the overall operations of the facility. The governing board appoints the administration, approves the facility's policies and procedures, and generally oversees the facility's operation .and compliance with applicable state, federal, and corporate rules and regulations .The responsibilities of the governing board shall be, at a minimum, to .provide facility services and quality resident care in accordance with professional standards of practice and principles . 2. Review of a facility policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated , d+[DATE], 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 .The objectives of the QAPI Plan are to .Provide a means to identify and resolve present and potential negative outcomes related to resident care and services .The owner and/or governing board (body) of our facility shall be ultimately responsible for the QAPI Program .This committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committees .The committee shall .monitor all corrective activities for appropriateness and/or the need for alternative measures .The QAPI Committee, Administrator, and the governing board shall review and approve a summary of problems and corrective measures . 3. Review of a job description of the Executive Director/Administrator dated [DATE], revealed .POSITION SUMMARY: Directs day-to-day operations of a skilled nursing facility in accordance with current, federal, state, and local laws, regulations and guidelines .ESSENTIAL DUTIES AND RESPONSIBILITIES .Directs the day-to-day operations of a skilled nursing facility .Ensures delivery of quality skilled nursing .services to residents .Employs and supervises competent and qualified department managers .Makes reports/recommendations to the facility's governing body .Serves on facility committees .Quality Assurance & Assessment .Other Specific Requirements .Thorough knowledge of federal, state and local laws regulations and guidelines that pertain to skilled nursing facilities .Must be knowledgeable of nursing and medical practices and procedures, as well as laws regulations and guidelines that pertain to long-term care . Review of a job description for the Director of Nursing (DON), dated [DATE], revealed .POSITION SUMMARY: To assist in the management and direction of the Nursing Department in accordance with federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and Medical Director, to ensure that the highest degree of quality care is maintained at all times. As the Director of Nursing, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .ESSENTIAL DUTIES AND RESPONSIBILITIES .Manages and directs all aspects of the Nursing Services Department .Supports the Quality Assessment & [and] Assurance Committee in developing and implementing appropriate plans of action to correct identified deficiencies .Serves on facility committees .Quality Assessment and Assurance . Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long-term care . (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a job description of the Clinical Resource (Director) (a member of the Governing Body) dated [DATE], revealed .Position Summary: The primary purpose of your job position is to establish and evaluate clinical systems in SNF [Skilled Nursing Facilities] communities .Duties and Responsibilities .Adheres to and assures compliance with Code of Conduct, facility policies and procedures and all applicable rules, regulations and standards as promulgated by Federal, State, and accrediting agencies or regulating bodies . This include .Department of Health, Centers of Medicare and Medicaid Services [CMS], and other applicable regulatory agencies .Responds to field clinical request and needs such as clinical audits and training .Taking part in Quality Improvement initiatives, including Focused Reviews and Improvement Plans .Supports field leaders with clinical training and development processes . 4. The facility failed to develop and implement a care plan to include the code status for Residents #3, #8, #9, and #10. Refer to F-656. 5. During interviews through the survey from [DATE]-[DATE], CNA A, CNA B, CNA C, CNA D, CNA E, CNA F, CNA G, CNA I, CNA J, CNA K, CNA L, CNA M, CNA N, CNA O, Housekeeper A, LPN C, LPN D, LPN E, PTA A, and RN C denied having education or in-service related to POST forms, the new POST form process, education on the Code Book, or verifying a code status before performing CPR until the week of [DATE] (after surveyor entered the building). The interviewed licensed staff, LPN C, LPN D, LPN E, and RN C stated they were aware a code status needed to be verified before performing CPR due to being a nurse and not by being provided education at the facility. The interviewed licensed staff stated they were aware of the contents and location of the code book but did not feel it was accurate or up to date and only used the EMR for verification of a code status. All interviewed unlicensed, direct and in-direct care staff stated they were not familiar with the code book, its contents, and/or it's location. During an interview on [DATE] at 11:30 AM, the Administrator stated codes (Code Blue) and residents who received CPR were discussed in the daily meetings after the events occurred. The Administrator stated she was not aware untrained staff had performed CPR and agreed she should have known or been made aware. The Administrator stated she believed the facility had an effective QAPI program until learning of staff performing CPR who were not certified or trained, staff having intentions on performing CPR who were not certified or trained, and staff not being aware of the code book location in the event of emergencies. The Administrator confirmed she was not aware the CPR documentation completed after the code events did not contain all the required information on all staff who participated or performed CPR. The Administrator confirmed further education and communication was needed to prevent recurrence. During an interview on [DATE] at 12:15 PM, the Clinical Resource Director stated he had been employed with the company for approximately 1 month (date of hire was [DATE]). The Clinical Resource Director stated he had attended QAPI meeting and had not been made aware CPR had been performed on 3 residents from ,d+[DATE]-,d+[DATE] by staff who were not certified in CPR. The Clinical Resource Director stated he and the QAPI committee should have known and agreed staff needed further education. The Clinical Resource Director stated he expected staff who performed CPR be trained and certified in CPR before performing the life sustaining measures. (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. The Governing Body failed to maintain effective leadership and oversight related to CPR/DNR or code status protocols. Refer to F-678. 7. The Governing Body failed to maintain oversight, establish, and implement policies and procedures to ensure all staff were educated related to the code book, its contents or location and accuracy, code status protocols, performing CPR without being CPR certified, or the likelihood of staff performing CPR when not CPR certified. Refer to F-726. 8. The Governing Body failed to maintain oversight, establish, and implement policies and procedures to ensure Administration consistently followed policies and procedures, and failed to provide leadership to the Administrative staff to identify patterns of non-compliance and put effective action plans in place to prevent recurrence. Refer to F-835. 9. The facility failed to ensure medical records regarding Cardio-Pulmonary Resuscitation (CPR) were complete and accurate for Residents #3, #8, #9, and #10. Refer to F-842 10. The Administration failed to maintain oversight, establish, and implement policies and procedures to ensure an effective QAPI program that identified and corrected non-compliance that was identified in the facility. Refer to F-867. An acceptable removal plan for F-837 was received on [DATE] at 9:48 PM. Validation of the Removal Plan to remove the immediacy of the Jeopardy (IJ) was conducted on [DATE] through review of facility documentation review, medical record reviews, and interviews. The removal plan dated [DATE] as follows: Failure to honor Resident #3's wishes for end-of-life treatment and accurately reflecting Do Not Resuscitate in medical record: Resident #3 was transferred to the hospital on the date of the incident ([DATE]) and returned to the facility on [DATE]. Upon return to the facility, Medical Records and Licensed Nurses re-verified her preference related to resuscitation and obtained a physician's order for DNR (Do Not Resuscitate). (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Since code status is applicable to all residents, Medical Records, under the direction of the Administrator, audited all residents' POST forms (or absence thereof) and verified that the Physicians' Orders in the Electronic Medical Record (EMR) matched what was on the POST forms. This audit was completed on [DATE]. No discrepancies were identified during the audit. Ad hoc QAPI meeting held at 4:00 PM on [DATE]. Purpose to discuss and review all IJ templates and removal plan. Members present were the Medical Director, Administrator, DON, Governing Body, RN Charge nurse, Assistant Director of Nursing (ADON), and the Minimum Data Set nurse. QAPI meetings on [DATE] and [DATE] resulted in the following: -On [DATE] the Code Blue binder changed to a bright blue binder to ensure staff would recognize during code blue event. - On [DATE] the education discussed above, all employees who received education have been provided with a small quick reference card labeled Code Blue that they will attach to the back of their name badge which says: Unresponsive = Call for help; Do not do CPR if not certified; Code book at nurses station; Crash cart in break room; Clear hallway; and Assist Emergency Medical Services (EMS) to location. Any employees/new hires that haven ' t received the education and cards will be provided before their next shift by DON (or designee). -CPR Code Blue questionnaire created on [DATE], and the CPR policy was revised during Ad Hoc QAPI on [DATE] and will be followed. Employees on duty [DATE] after 6:00 PM were in-serviced on the revised policy. The facility will arrange for an outside CPR Certification Course provider to hold a CPR Certification Course for all interested employees at least 4 times per year. Facility will ensure that CPR certified staff will be available at all times. HR staff (or designee) will verify CPR certification and obtain a copy of current CPR certification card for all new hires. HR staff (or designee) will maintain a list of CPR certified employees by expiration month. Medical Records audited all residents' POST forms on [DATE] and found them up to date and all matching. Medical Records will perform POST form audits at least monthly and verify that the Physician's Order in the EMR matches the POST form. The Clinical Interdisciplinary Team (IDT) (DON, ADON, MDS, Social Services) will audit any new or revised POST forms during clinical meeting daily Monday-Friday. Any issues will be immediately brought to the DON (or designee) for correction. Audit results will be brought by the DON (or designee) to the QAPI Committee (Medical Director (MD), DON, Administrator, Social Services, Minimum Data Set (MDS), RN Supervisor, Infection Control RN, Environmental Services (EVS) supervisor, Certified Dietary Manager (CDM), Maintenance) at the next meeting and moving forward. QAPI committee to provide additional recommendations as necessary. Following each code blue incident, DON and Administrator (or their designees) will review the event the next business day during morning meeting with the IDT to verify: (1) that advanced directives were followed, and if CPR was performed that (2) the RN Charge Nurse documented the names of the individuals who performed CPR on the Code Blue Checklist and (3) it was performed by CPR certified individuals. Administrator (or designee) will arrange ad hoc QAPI meeting the same day to respond to any instances of noncompliance. (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During regular QAPI meetings, the committee will also review all code blue events since the last meeting and verify CPR was not initiated for anyone with Advance Directive documentation for DNR, and to verify CPR was only performed by individuals with CPR certification. QAPI committee will provide additional recommendations as needed. All employees who are members of the QAPI committee received the above training on [DATE], or if not present as of 10:00 AM, they will receive the training on their next scheduled workday. On [DATE], the Administrator interviewed a sample of 8 employees on CPR policies. Administrator (or designee) will interview 10 random employees weekly to include day, night, and weekend shifts for the next month, and then monthly thereafter. The administrator asked the following questions: In the event a resident appears to need CPR, who can perform CPR? If you are helping respond to a code blue incident, how can you help verify a resident's code status? On [DATE], the Administrator interviewed 3 licensed charge nurses on the Code Blue Checklist/Documentation. Administrator (or Designee) will continue interviewing 3 Licensed Charge Nurses weekly for the next month. The question included is What form do you fill out during a code blue event? (Code Blue Checklist/Documentation attached for review) If needed, additional training will be provided by DON (or designee) based on responses to the above interviews. Governing Body Representatives (Operations Resource Director and Clinical Resource Director) provided education remotely and in person to the Administrator and Director of Nurses on [DATE] regarding all the above. Beginning on [DATE], A Governing Body Representative will review all code blue checklists and sign the code blue checklist form confirming review. All Code Blue events will be reviewed during each QAPI meeting and placed on the agenda. Results of the employee interviews referenced above, will be reviewed by a member of the Governing Body with the Administrator at least weekly for the next 3 months. A member of the Governing Body will review QAPI minutes related to code blue events and effectiveness of the above interventions following each of the next 3 meetings, and then at least quarterly thereafter. The Governing Body will provide additional education and training as necessary based on findings, interviews, and review of QAPI minutes. Surveyor verified and validated the removal plan for F-837, dated [DATE] as follows: Surveyor reviewed facility documentation of a CPR Training sign-up sheet for all staff. The training will be in , d+[DATE]. The CPR Training sign-up sheet was located on the break room door and the break room. Surveyor reviewed a Mock Code Evaluation Checklist dated [DATE] at 9:50 PM and revealed 5 CNAs and 1 LPN participated with no issues identified. The check list included the names of participants, the time of actions, notifications, and status of resident. Surveyor reviewed a Mock Code Evaluation Checklist dated [DATE] at 9:55 PM and revealed no issues. Surveyor reviewed the revised CPR policy dated [DATE] with changes related to adding CPR classes 4 times per year and only CPR certified staff will participate in CPR. (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor reviewed and validated the revised CPR policy was signed by 125 employees of the facility. Those on leave/vacation will sign upon their return. Surveyor reviewed a POST form audit on all residents conducted on [DATE] with 100% Compliance. Surveyor selected a random selection of 20 residents for the code status on the POST form matched the physician's orders and the electronic medical record with no issues or concerns identified. Surveyor reviewed an in-service training related to the Code Blue Checklist dated [DATE]. The education conducted by the ADON revealed 12 nursing staff received the education. Those not on duty/leave will be educated upon their return to work. Surveyor conducted interviews on [DATE] with 4 RNs, 7 LPNs, the DON, and the Administrator who confirmed understanding of the Code Blue Checklist. Surveyor verified by observation the Code Blue Checklist was located on the crash cart in the breakroom. Surveyor reviewed a QAPI sign in sheet dated [DATE] and revealed the required parties attended the meeting and the following was discussed: Immediate Jeopardy templates of F678, F726, F835, F837, and F867. Action steps with assigned responsible staff were included. Surveyor reviewed in-service education and sign-in sheets regarding POST forms conducted on [DATE] with 17 staff members. On [DATE], Surveyor interviewed 5 Housekeeping/Laundry Staff, 13 CNAs, 4 RNs, 7 LPNs, the Environmental Services Director, Social Services Director, Licensed Clinical Social Worker (LCSW), the Maintenance Director, the Medical Records Director, the ADON, the DON, and the Administrator and all staff were able to verify they had received the education and the process and steps when POST forms were received or changed. Surveyor reviewed a CPR/Code Blue Questionnaire which revealed 125 employees received the questionnaire on ,d+[DATE] or [DATE] by the Administrative staff. Surveyor verified the questionnaires were completed and documented by the 125 employees. CNA questionnaire included: What would you do if you found a resident that is not responsive? What is your role during a code blue? Can you do CPR if you are NOT currently certified? Are you currently CPR certified? RN questionnaires completed which include: What form do you fill out during a code blue event? The answer Code Blue Checklist. 3 RNs were questioned by the Administrator. Administrator questioned a sample of 8 employees on [DATE] regarding the following: In the event a resident appears to need CPR, who can perform? (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	If you are helping respond to a code blue incident, how can you help verify a resident ' s code status? Do you want to become CPR certified? The sample of employees included the housekeeping supervisor, Activities Director, Night Shift Laundry Staff, 4 CNAs, 2 LPN. Surveyor interviewed the staff on [DATE] and verified their understanding of the CPR process and only trained and certified staff were to perform CPR. Continued interview revealed the staff were knowledge about the Code book and the crash cart and where to locate the items. All interviewed staff were knowledgeable of their roles during a code situation and knew only trained and certified staff in CPR were to perform CPR. Review of a newly implemented card on [DATE] to be placed on every employee ' s badge revealed: CODE BLUE Unresponsive - Call for Help Do Not do CPR if not certified Crash cart in Breakroom Clear Hallway Assist EMS to Location. On [DATE], Surveyor observed and interviewed 5 housekeeping/laundry staff, 13 CNAs, 4 RNs, 7 LPNs, the Environmental Services Director, Social Services Director, Maintenance Director, Medical Records Clerk, Activities Director, and the LCSW. All staff wore the newly implemented Code Blue badge and was able to correctly state what to do in the event a resident became unresponsive or went into cardiac or respiratory arrest. On [DATE], Surveyor interviewed the Administrator and the DON who stated they had received education and/or in-service by the Clinical Resource Director, and both were able to state the new process of POST forms, verbalize understanding of the new CPR checklist document. The Administrator and the DON educated the RNs and LPNs on duty regarding the process, the code book placement and use and the new CPR checklist and who was to record or scribe during a code situation. Interviews on [DATE] with 4 RNs and 7 LPNs revealed their understanding of the scribe/recording process on the CPR checklist and their roles in a code situation. Refer to F-656, F-678, F-726, F-835, F-842, and F-867

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39794 Based on job description review, medical record review, facility documentation review, and interview, the facility failed to ensure medical records regarding Cardio-Pulmonary Resuscitation (CPR) were complete and accurate for 4 residents (Residents #3, #8, #9, and #10) of 5 resident medical records reviewed for CPR. The findings include: Review of a job description for the Licensed Practical Nurse (LPN) dated [DATE], revealed .ESSENTIAL DUTIES AND RESPONSIBILITIES .Perform administrative duties regarding assigned residents, such as completing medical forms, reports .Make written and oral reports .to the attending physician, Medical Director, or the Administrator concerning the status and care of the assigned resident .Review medication cards for completeness of information, accuracy in the transcription of the physician's order .Chart nurses' notes in professional and appropriate manner that timely, accurately and thoroughly reflects the care provided to the resident .Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures and applicable state and federal regulations . Review of a job description for the Registered Nurse (RN) dated [DATE], revealed .ESSENTIAL DUTIES AND RESPONSIBILITIES .Perform administrative duties regarding assigned residents, such as completing medical forms, reports .Make written and oral reports .to the attending physician, Medical Director, or the Administrator concerning the status and care of the assigned resident .Review medication cards for completeness of information, accuracy in the transcription of the physician's order .Chart nurses' notes in professional and appropriate manner that timely, accurately and thoroughly reflects the care provided to the resident .Chart all reports of accidents/incidents involving residents .Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures and applicable state and federal regulations .Verify that nurses' notes reflect that the care plan is being followed when administering nursing care or treatment . Review of the job description for the Director of Nursing (DON) dated [DATE], revealed .POSITION SUMMARY: To assist in the management and direction of the Nursing Department in accordance with current federal, state, and local standards, guidelines, and regulations .to ensure that the highest degree of quality care is maintained at all times .ESSENTIAL DUTIES AND RESPONSIBILITIES .Reviews nursing personnel medical record documentation to ensure that it is appropriately and accurately descriptive of the nursing care provided . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Chronic Congestive Heart Failure, Muscle Weakness, Diabetes Mellitus, and Systemic Lupus Erythematosus. Review of a physician's order for Resident #3 dated [DATE], revealed CPR/Full Code. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Tennessee Physician Orders for Scope of Treatment (POST) form dated [DATE], revealed Resident #3 selected .Do Not Attempt Resuscitation (DNR/no CPR) (Allow Natural Death) . The POST form was signed and dated by the Physician on [DATE]. Review of the Medication Administration Record (MAR) on the electronic medical record (EMR) dated for the month of ,d+[DATE], revealed .CPR/Full code . Continued review revealed the EMR was not changed to reflect the change of the DNR code status. Review of a facility document titled, CPR/Code Blue Documentation, dated [DATE], revealed Resident #3 was . discovered unresponsive in the dining room at 1:20 PM .CPR was initiated at 1:21 PM .Physician and son [message left to return call] notified by phone at 1:30 PM .CPR was paused at 1:38 PM with return of respirations .residents' [resident's] son returned call at 1:42 PM wanted to continue the DNR status and did not want the resident sent to the hospital. Review of a facility investigation for Resident #3 dated [DATE], revealed the facility notified the Physician and Resident #3's family of the event (where CPR was performed on Resident #3 against the resident's DNR wishes), conducted a Quality Assurance Performance Improvement (QAPI) meeting, and determined the Root Cause Analysis (RCA) for the event was the failure of staff to enter the new physician's orders from the POST form for a DNR status dated [DATE], in the EMR. During an interview on [DATE] at 10:00 AM, RN F stated she responded to Resident #3's room and told LPN D she would continue the chest compressions and RN G continued with the respirations. Further interview confirmed after the 2nd round of CPR, the resident's pulse and respirations were checked and observed Resident #3 was breathing on her own, had a weak pulse, and CPR was stopped. During an interview on [DATE] at 10:15 AM, RN G stated RN A checked the EMR and stated Resident #3 was a full code. Continued interview revealed RN G called 911 for assistance and RN A paged over head for a code blue. Continued interview confirmed LPN D began chest compressions and RN G initiated respirations with the ambu bag (a manual medical device used to force air into the lungs in emergent situations when someone is not breathing or having difficulty in breathing). During an interview on [DATE] at 10:40 AM, Social Services Director (SSD) stated she was on duty and heard the code blue called for Resident #3. The SSD stated she printed out the paperwork for Emergency Medical Services (EMS) which included the resident's POST form, realized Resident #3 had requested not to have CPR and had a DNR code status, immediately took the POST form to Resident #3's room, and notified the nursing staff of the DNR. During an interview on [DATE] at 11:00 AM, the Medical Records Director stated she was responsible for obtaining a signature from the Physician on a POST form, she scanned the POST form into the EMR, then gave the form to the nurse to enter the order in the EMR. The Medical Records Director stated the facility's process was not followed and the order for Resident #3's code status was not changed from a Full code status to a DNR code status on [DATE]. During an interview on [DATE] at 2:13 PM, the DON stated it was her expectation for residents found unresponsive for Registered or Licensed nursing staff to verify the resident's code status before performing CPR. The DON stated the staff had failed to change the order to DNR in the EMR after the POST form was updated for Resident #3. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri State Health and Rehabilitation Center	600 Shawanee Rd Harrogate, TN 37752

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic Respiratory Failure with Hypoxia, Cognitive Communication Deficit, Chronic Obstructive Pulmonary Disease, Diabetes, Obstructive Sleep Apnea, Neuromuscular Dysfunction of the Bladder, Bipolar Disorder, and a history of Stroke. Review of a POST form for Resident #8 dated [DATE] (from previous admission to the facility), revealed the form was signed and dated by the physician on [DATE]. Continued review revealed Resident #8 requested CPR and full treatment. Review of a Physician's order for Resident #8 dated [DATE], revealed the resident had an order for CPR/Full Code. Review of a nurse's note for Resident #8 dated [DATE], revealed Resident #8 was found unresponsive at 5:55 AM. Chest compressions were started and EMS was notified. EMS arrived at 6:11 AM. Resident #8 was pronounced deceased at 6:32 AM. Continued review of the nurse's note revealed no documentation of all staff members who participated or performed CPR on Resident #8. Review of a facility document for Resident #8 titled, CPR/Code Blue Documentation, dated [DATE], revealed the document was completed by LPN H. The event (cardiac arrest situation for Resident #8) which occurred at 5:55 AM was unwitnessed. EMS was called at 5:55 AM and arrived at the facility at 6:11 AM. The document noted RN D and LPN H participated in the code. Resident #8 was pronounced deceased at 6:32 AM. The section .Last time person seen prior to event . was left blank. Interviews conducted on [DATE], revealed RN E, LPN D, CNA K, and CNA N participated or performed CPR for Resident #8 on [DATE] in addition to LPN H and RN D. All participating staff members were not noted on the CPR/Code Blue Documentation. During an interview on [DATE] at 4:39 PM, RN D stated on [DATE] Resident #8 was found unresponsive at shift change. RN D stated CNA K and CNA N assisted with the code but could not recall who had initiated CPR. RN D stated LPN D, CNA K and CNA N (CNA N was not CPR certified) assisted with the chest compressions until EMS arrived. During a telephone interview on [DATE] at 5:05 PM, CNA K stated she participated in Resident #8's code on [DATE]. CNA K stated she and CNA M .grabbed the crash cart [located in the break room] and went to the room [Resident #8's room] . CNA K stated RN E, LPN D, and RN D were already in Resident #8's room. CNA K stated CPR was initiated by RN E and after a few minutes, she took over chest compressions from RN E. CNA K stated CNA N (CNA N was not CPR certified), LPN D, and RN D also took turns with the ambu bag and chest compressions until EMS arrived. During a telephone interview on [DATE] at 5:35 PM, CNA N stated there was a code with a male resident a few months ago (was unable to recall the resident's name or date, later determined it was Resident #8). CNA N stated .I did put my hands on him, they [unable to recall the staff who requested assistance] asked me to .I don't really remember the situation. I left after the ambulance came . CNA N stated she was not trained or certified in CPR. CNA N stated .I only had my hands on him a few minutes just to help out .the other people in the room did most of it . (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Dysphagia (Difficulty Swallowing), Cerebral Infarction (Stroke), Protein Calorie Malnutrition, Diabetes, Anemia, Dementia, Chronic Kidney Disease Stage 2, and Chronic Obstructive Pulmonary Disease. Review of a POST form for Resident #9 dated [DATE], revealed the form was signed and dated by the physician on [DATE] for CPR and full treatment. Review of a physician's order for Resident #9 dated [DATE], revealed the resident had a full code status (CPR). Review of the facility document for Resident #9 titled, CPR/Code Blue Documentation, dated [DATE], revealed the form was completed by LPN E. The event (cardiac arrest situation for Resident #9) which occurred at 4:15 AM was unwitnessed. EMS was called at 4:15 AM and arrived at the facility at 4:50 AM. The document noted LPN E and LPN G participated in the code. Resident #9 was pronounced deceased at 4:50 AM. Continued review revealed the section .Last time person was seen prior to event . was left blank. Interviews conducted on [DATE] and [DATE] during the survey revealed LPN E, LPN G, CNA A, and CNA G participated in CPR for Resident #9 on [DATE]. Further review revealed all staff members who participated in CPR were not documented on the form. Review of a nurse's note for Resident #9 dated [DATE] at 5:43 AM, revealed Resident #9 was observed with no visible signs of life or vital signs at 4:15 AM. CPR was initiated and EMS was notified. EMS arrived at 4:25 AM. EMS pronounced death of Resident #9 at 4:50 AM. Continued review revealed all staff members who participated in CPR were note documented. During an interview on [DATE] at 9:00 PM, CNA A stated he was not CPR certified. CNA A stated he had participated in a Code Blue situation with Resident #9 .a few weeks ago . CNA A stated he started chest compressions and assisted with the code until the paramedics arrived. During an interview on [DATE] at 10:30 PM, CNA G stated he was unsure if his CPR certification had expired .but I think so . CNA G stated the last code he participated in was a male resident that happened about a month ago (later determined it was Resident #9) and he and another nurse (LPN G) initiated CPR. CNA G stated CNA A also assisted with chest compression to help relieve staff. During a telephone interview on [DATE] at 4:04 PM, LPN G stated on [DATE], Resident #9 was found unresponsive by CNA A.We [LPN G and CNA G] went running down [to Resident #9's room] and we checked him, and we [LPN G and CNA G] proceeded to code him [CNA G was not trained or CPR certified]. LPN G stated CNA G and CNA A relieved her and assisted with chest compressions until LPN E arrived to help. LPN G stated LPN E, LPN I, CNA A, and CNA G assisted in performing CPR with chest compressions or the ambu bag until EMS arrived to take over the code. LPN G stated EMS notified the hospital ER physician and Resident #9 was pronounced deceased by EMS at the facility at 4:50 AM. Review of hospital admission orders for Resident #10 dated [DATE], revealed .ADMIT .TO [Facility] .FOR SHORT TERM .ON [DATE] .admitted TO HOSPICE WITH DIAGNOSIS OF PARKINSONS .FULL CODE . Review of a POST form for Resident #10 dated [DATE], revealed the form was signed and dated by the physician on [DATE] for CPR and full treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	09/26/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Physician's Order Summary Report for Resident #10 dated [DATE] (3 days prior to admission, obtained from the POST order), revealed the resident had a CPR/Full Code status. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Diabetes, Severe Protein-Calorie Malnutrition, Dementia with Psychotic Disturbance, and Major Depressive Disorder. Review of a nurse's note for Resident #10 dated [DATE], revealed the resident was noted to be unresponsive and without a pulse. CPR was initiated at 4:05 PM and EMS was notified. Resident #10 was transferred out of the facility by EMS at 4:40 PM. Continued review revealed all staff members who participated in CPR were not documented. Review of a facility document for Resident #10 titled, CPR/Code Blue Documentation, dated [DATE], revealed the document was completed by RN E. The event (cardiac arrest situation for Resident #10) which occurred at 4:00 PM was unwitnessed. EMS was called at 4:00 PM and arrived at the facility at 4:40 PM. The document noted RN E performed CPR. Resident #10 was transferred to hospital via (by way of) air support and expired at the hospital at 5:59 PM on [DATE]. Continued review revealed the section .Last time person was seen prior to event . and the Signature line was left blank. Interviews conducted on [DATE], [DATE], and [DATE] conducted during the survey revealed RN E, CNA C, and CNA O participated in CPR for Resident #10. Continued review all staff members who participated in CPR was not documented on the form. During an interview on [DATE] at 9:38 PM, CNA C stated Resident #10 was found with no pulse, the nurse was notified, and CPR was initiated. CNA C stated she performed CPR until another nurse verified the code status and was told CPR was to be continued. During an interview on [DATE] at 10:48, LPN D stated she was CPR certified and had participated in a code with Resident #10 approximately ,d+[DATE] weeks ago. LPN D stated she and CNA C (CNA C was not trained or CPR certified) started CPR. During a telephone interview on [DATE] at 4:19 PM, RN E stated one of the CNA's said Resident #10 was not responding and did not know his code status. RN E stated Resident #10's code status was checked by the resident's primary nurse, LPN D, who was at the nurse's station. RN E stated it was unknown who initiated CPR on Resident #10. RN E stated CNA C and CNA O helped with the ambu bag but was unsure if they performed chest compressions. RN E stated the resident was transferred by life flight to the hospital and was notified by the hospital a short time later the resident had expired. During a telephone interview on [DATE] at 4:34 PM, CNA C stated on [DATE], another CNA found Resident #10 unresponsive and she and CNA O got the crash cart out of the break room and took it to Resident #10's room .One of the nurse's started CPR but I don't know their name .I [CNA C] think I am CPR certified [CNA C was not trained or CPR certified] or I think I was and I helped them .I relieved one of the nurse's and did chest compressions on him . During an interview on [DATE] at 2:13 PM, the DON stated she had not been made aware untrained, non-CPR certified staff had performed CPR on Residents #8, #9, and #10. (continued on next page)

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	445263	A. Building B. Wing	09/26/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:30 AM, the Administrator stated codes (Code Blue) and residents who received CPR were discussed in the daily meetings after the events occurred. The Administrator stated she was not aware untrained staff had performed CPR and agreed she should have known or been made aware. The Administrator agreed all staff members who participated in CPR on Residents #8, #9, and #10 were not documented on the CPR/Code Blue Documentation which may have contributed to Administration not being aware of the untrained staff performing CPR.

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	445263	A. Building B. Wing	09/26/2024

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 39794 Based on facility document review, facility policy review, job description review, Quality Assurance and Performance Improvement (QAPI) Plan review, QAPI Meeting Minutes review, and interviews, the facility's QAPI committee failed to ensure an effective QAPI program that identified quality deficiencies, implement performance improvement activities to address quality concerns, and perform a root cause analysis related to residents' code status', end of life wishes, and staff performing Cardio-Pulmonary Resuscitation efforts who were not trained or certified in CPR. The facility's QAPI committee failed to develop and implement effective processes to include the effective training of staff after identifying CPR was performed on 1 resident (Resident #3) against the resident's Physician's Order for Scope of Treatment (POST) and end of life wishes, failed to identify and have effective action plans in place to correct deficiencies when non-CPR certified and untrained staff performed CPR on 3 residents (Residents #8, #9, and #10) from ,d+[DATE]-,d+[DATE], and failed to identify, educate, and put action steps in place when Certified Nursing Assistants (CNAs) and Housekeeping Staff who were not CPR certified expressed an intent to perform CPR without having the adequate training or certification, in the event of cardiac or respiratory arrest of a resident. The facility's failure to have an effective QAPI program, implement effective education related to the residents' code status, CPR, and POST forms resulted in an Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) which had the potential or likelihood to impact all residents of the facility. The Administrator and the Director of Nursing Services (DON) were notified of the Immediate Jeopardy (IJ) for F-867 on ,d+[DATE] at 3:30 PM, in the conference room. The facility was cited Immediate Jeopardy at F-867 at a scope and severity of K. The facility was cited Immediate Jeopardy at F-678 at a scope and severity of K which constituted substandard quality of care. The facility was cited Immediate Jeopardy at F-726, F-835, and F-837, at a scope and severity of K. A partial extended survey was conducted onsite from [DATE] through [DATE]. The IJ began on [DATE] and continued through [DATE]. The IJ ended on [DATE] and was removed on site. An acceptable Removal Plan which removed the immediacy was provided by the facility on [DATE] at 9:48 PM for F-867. The corrective actions were validated on site by the surveyor on [DATE] for F-867. Noncompliance continues at F-867 at a scope and severity of E. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility is required to submit a Plan of Correction (POC). The findings include: Review of an undated, facility document titled, Governing Board, revealed .The governing board is the corporate entity or licensee responsible for the overall operations of the facility. The governing board appoints the administration, approves the facility ' s policies and procedures, and generally oversees the facility ' s operation .and compliance with applicable state, federal, and corporate rules and regulations .The responsibilities of the governing board shall be, at a minimum, to .provide facility services and quality resident care in accordance with professional standards of practice and principles . Review of a facility policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated , d+[DATE], 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 .The objectives of the QAPI Plan are to .Provide a means to identify and resolve present and potential negative outcomes related to resident care and services .Provide structure and processes to correct identified quality and/or safety deficiencies .Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome .Help departments . that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability .Provide a means to centralize and coordinate comprehensive QAPI activities in order to meet the needs of the residents and the facility .Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program .The owner and/or governing board (body) of our facility shall be ultimately responsible for the QAPI Program .The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements .The QAPI Committee shall oversee implementation of our QAPI Plan .This committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committees .The QAPI Committee shall oversee and authorize QAPI activities, including data-collection tools, monitoring tools, and the basis for and appropriateness and effectiveness of QAPI activities .The committee shall approve any corrective actions, including changes in policies and/or procedures, employment practices, standards of care .shall also monitor all corrective activities for appropriateness and/or the need for alternative measures .The QAPI Committee, Administrator, and the governing board shall review and approve a summary of problems and corrective measures . Review of a job description of the Executive Director/Administrator dated [DATE], revealed .POSITION SUMMARY: Directs day-to-day operations of a skilled nursing facility in accordance with current, federal, state, and local laws, regulations and guidelines .ESSENTIAL DUTIES AND RESPONSIBILITIES .Directs the day-to-day operations of a skilled nursing facility .Ensures delivery of quality skilled nursing .services to residents .Employs and supervises competent and qualified department managers .Makes reports/recommendations to the facility's governing body .Serves on facility committees .Quality Assurance & Assessment .Other Specific Requirements .Thorough knowledge of federal, state and local laws regulations and guidelines that pertain to skilled nursing facilities .Must be knowledgeable of nursing and medical practices and procedures, as well as laws regulations and guidelines that pertain to long-term care . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a job description for the Director of Nursing (DON), dated [DATE], revealed .POSITION SUMMARY: To assist in the management and direction of the Nursing Department in accordance with federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and Medical Director, to ensure that the highest degree of quality care is maintained at all times. As the Director of Nursing, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .ESSENTIAL DUTIES AND RESPONSIBILITIES .Manages and directs all aspects of the Nursing Services Department .Makes rounds to ensure that nursing personnel perform their work assignments in accordance with acceptable nursing standards .Reviews nursing personnel medical record documentation to ensure that it is appropriately and accurately descriptive of the nursing care provided .Supports the Quality Assessment & [and] Assurance Committee in developing and implementing appropriate plans of action to correct identified deficiencies . Serves on facility committees .Quality Assessment and Assurance .Ensures that new nursing staff are properly oriented and trained .Develops, plans and conducts in-service training classes .Develop a written plan of care .for each resident that identified the problems/needs of the resident, indicates the care to be given, goals to be accomplished .Other Specific Requirements .Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long-term care . Review of a job description of the Clinical Resource (Director) (a member of the Governing Body) dated [DATE], revealed .Position Summary: The primary purpose of your job position is to establish and evaluate clinical systems in SNF [Skilled Nursing Facilities] communities .Duties and Responsibilities .Adheres to and assures compliance with Code of Conduct, facility policies and procedures and all applicable rules, regulations and standards as promulgated by Federal, State, and accrediting agencies or regulating bodies . This include .Department of Health, Centers of Medicare and Medicaid Services [CMS], and other applicable regulatory agencies .Responds to field clinical request and needs such as clinical audits and training .Taking part in Quality Improvement initiatives, including Focused Reviews and Improvement Plans .Supports field leaders with clinical training and development processes . Review of an undated, unsigned facility document revealed .Governing body notification to .Clinical Resource [Director] and .Market Leader on [DATE] by [Administrator/DON] by phone after our QAPI meeting . The facility's governing body included the Administrator, Clinical Resource Director, and Market Leader. Further review of the document revealed the last annual governing body meeting was held on [DATE] . minutes and signatures attached . The document did not note the current performance improvement plans or an agenda. The document revealed the governing body members met inside and outside of the facility at least twice per month and via (by way of) teams weekly for cluster calls. The document revealed the Clinical Resource Director visited the facility and was actively involved with the facility by phone and remotely as needed. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility document (attached to the undated and unsigned facility Governing body notification for the date [DATE] annual meeting) titled, QAPI [DATE] Meeting Minutes, revealed the document was a sign in sheet and was dated [DATE] (and not [DATE] as indicated on the attached document). The documents were provided by the Administrator, as part of the Governing Body meeting minutes. The meeting was attended by the Administrator, the Medical Director, Social Services Director (SSD), Minimum Data Set (MDS) Coordinator, Infection Preventionist, Accounts Receivable Coordinator, Clinical Resource Director, DON, Governing Body Operations Resource, and a Housekeeper. A second attached document was dated [DATE] (and not the [DATE] as noted on the unsigned and undated Governing body notification or the [DATE] Meeting Minutes sign in sheet). The second attached document revealed the document was meeting minutes and noted the staff in attendance included the Administrator, the DON, Clinical Resource Director the Governing Body Member, and Market Leader, the Medical Director, the Certified Dietary Manager, and the Infection Preventionist attended the meeting (a difference in attendees from the actual sign in sheet noted on [DATE]). The agenda of the [DATE] meeting did not address Physician's Order for Scope of Treatment (POST) forms, Advanced Directives, or CPR. The document revealed Code Blue (an announced code to alert staff of a cardiac or respiratory arrest and need for CPR) drills were reviewed as part of a Life Safety Review with no additional information related to the drills. Review of the facility document titled, QAPI ADHAWK [Ad Hoc] Meeting Minutes, dated [DATE], revealed the Administrator, DON, SSD, and Medical Director attended the meeting. The attached meeting document titled, Ad Hawk [Ad Hoc] QAPI today [DATE] regarding Post [POST] Form Review, revealed .Policy and Incident reviewed during meeting with Medical Director. While reviewing incident involving [Resident #3] [Resident #3 went into cardiac arrest, the staff performed Cardio-Pulmonary Resuscitation [CPR] against the resident's wishes] that occurred today [[DATE]] the Ad Hawk QAPI team has determined the root cause occurred when the POST form was scanned into the misc. [miscellaneous] tab [of the electronic medical record] [EMR] but was not changed in the order/banner section of the MAR [Medication Administration Record] within [EMR]. This caused the banner and order to reflect Full Code Status .Education given to Medical Records Manager, that moving forward she will be giving all post [POST] forms directly to DON or designee to ensure orders in the banner and [EMR] match the scanned post form .DON/Medical Records will follow PIP [Performance Improvement Plan] and report to QAPI team during each meeting until resolved by committee . Continued review of a PIP attached revealed .Issue .facility identified a post form scanned .not changed in the banner and order .not completed to reflect DNR [Do Not Resuscitate] .Goal .ensure that each post form is complete and matches the banner/order .Cause .Communication that the change has been made and audit of the post form order, banner vs [versus] the document scanned in [EMR] .Solution .QA [Quality Assurance] audit in place .DON will bring this [audit] to QAPI .Medical Records will audit new admissions .all residents will be audited monthly .Initial Audit done [DATE] . Continued review revealed no documentation from the ,d+[DATE] QAPI meeting that identified or addressed non-CPR certified staff intent to perform or performing CPR. Further review revealed no documentation related to the facility's code book (book which contained residents' POST forms to indicate code status) and no documentation to reflect all nursing staff had been educated or in-serviced on the new process for POST forms and code book. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Tri State Health and Rehabilitation Center	600 Shawanee Rd Harrogate, TN 37752

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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 - Some	Review of a facility document titled, Education for Medical Records/Admissions Post Forms, dated [DATE], revealed .To ensure POST FORMS match the respective advance directive order we are implementing a new procedure. After admissions reviews and completes a POST FORM with family it will be uploaded in the chart [Electronic Medical Record] [EMR] under 'Admission Agreement ' along with other required documents. Medical Records ensure POST FORMS are signed promptly, and upon physician signature, will review with DON or designee to ensure the order and physical form are synonymous and correct . Continued review revealed the document was signed by the Administrator, the DON, the Admission Director, the Medical Records Director, and the Licensed Practical Nurse (LPN) Case Manager. Review of a facility document titled, In-service Attendance Record .Course Title: Enhanced Barrier Precautions [EBP], dated [DATE], revealed handwritten on the document Round [NAME]. Continued review revealed 3 Registered Nurses (RNs), 2 LPNs, and 13 Certified Nursing Assistants (CNAs) signed they had received the in-service on EBP Precautions and Round [NAME]. A second attached sign-in sheet also dated [DATE] indicated an in-service was provided on EBP and Round [NAME] to an additional 22 CNAs, and 3 LPNs. Further review revealed the specific education was not attached to the sign-in sheet to reflect what was discussed during the round [NAME] meeting. Review of a QAPI Committee Meeting dated [DATE], revealed the Administrator, the DON, the Infection Preventionist, a Housekeeping/Laundry staff, the Maintenance Director, the Admissions Coordinator, the Medical Records Clerk, an Admissions Licensed Practical Nurse (LPN), MDS Coordinator, the Director of Rehabilitation, and the Assistant Director of Nursing (ADON) attended the meeting. The QAPI minutes revealed POST form Audits were completed and were 100% compliant. Continued review revealed no documentation related to the facility's code book, or that non-CPR certified staff intended to perform or did perform CPR. Further review revealed no documentation that all nursing staff had been educated or in-serviced on the new process of the POST forms and code book. Review of the QAPI Committee Meeting dated ,d+[DATE]-,d+[DATE], revealed the Administrator, the DON, the Medical Director, an RN, a Housekeeping staff, the Assistant Director of Nursing (ADON), the Admissions Coordinator, the MDS Coordinator, and a Nursing Supervisor attended the meeting. The QAPI minutes revealed the old business discussed was of the POST form audit from the ongoing PIP. The new business included a POST form audit which was noted to be 100% compliant. Continued review revealed no documentation that all nursing staff had been educated or in-serviced on the new process of the POST forms, the code book, or that non-CPR certified staff intended to perform or did perform CPR. Review of the QAPI Committee Meeting dated [DATE], revealed the Administrator, the Medical Director, the Infection Preventionist, an RN, and the DON attended the meeting. The QAPI minutes revealed the POST form PIP audit was 100% compliant. Continued review revealed no documentation that all nursing staff had been educated or in-serviced on the new process of the POST forms, the code book, or that non-CPR certified staff intended to perform or did perform CPR. During review of facility documentation provided during survey dated from [DATE]-[DATE], revealed the facility had implemented a plan related to Resident #3 receiving CPR against the POST form order and end of life wishes for DNR on [DATE]. The education included a POST form being placed in a book or binder located at the nurse's station and included all residents' POST forms indicating the residents' code status. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:18 PM, the ADON stated in-services and round [NAME] meetings were held with nurses and CNA ' s weekly to keep staff updated on any issues and the meetings allowed staff to address any concerns they may have. The ADON stated on [DATE] all staff on duty that day were educated on POST forms, code status', the Code Book, and checking the code status before proceeding with CPR. The ADON stated the Code Book had always been located at the nurse's station and was not a new process. The ADON stated all staff were educated through the round [NAME] meetings. The ADON stated it was her expectation CPR not to be initiated until the verification of the resident's code status. The facility's QAPI committee failed to identify non-compliance related to CPR/DNR or code status protocols, failed to ensure staff were educated related to the code book, its contents or location, and accuracy, code status protocols, performing CPR without being CPR certified, or the likelihood of staff performing CPR when not CPR certified. The QAPI committee failed to maintain oversight and have an effective QAPI program to prevent or address patterns of non-compliance. During an interview on [DATE] at 2:13 PM, the DON stated it was her expectation that all staff who perform CPR be CPR certified. The DON further stated she had not been made aware untrained staff had performed CPR and was not aware untrained, non-CPR certified staff expressed the intent to perform CPR. The DON stated the licensed nursing staff were educated on the new POST process and code book after the [DATE] incident with Resident #3 and was unsure why the staff had indicated they had not received the in-service. During a telephone interview on [DATE] at 2:30 PM, the Medical Director stated all staff who perform CPR should be trained to do CPR with Basic Life Support to be able to use the ambu bag and CPR and know to call 911. The Medical Director stated he would rather the staff initiate CPR, then verify the code status, and then stop CPR if it was determined the resident had a DNR order.it ' s a tricky slope. If you wait too long [delay in performing CPR] .3 minutes brain damage . The Medical Director stated there should not be a delay in performing CPR waiting on staff to verify a code status.If you don ' t start CPR right away then you loose , d+[DATE] minutes .valuable minutes . Let ' s say go ahead and start CPR .if wait to get the book [code book which contains the residents ' POST forms] then you ' ve lost that time .But, if [staff] start CPR on someone [a resident] who is a DNR then .run the risk of running into the same problem again [performing CPR on a resident who has DNR code status, which occurred on [DATE] with Resident #3] .This [code status, code verification implementation] is something we [the Medical Director and the facility ' s administrative staff] will need to discuss with the DON and the nursing staff. The Medical Director confirmed only CPR trained staff should perform CPR and was not aware untrained, non-CPR certified staff had performed CPR on Residents #8, #9, and #10. The Medical Director stated the facility needed to follow orders and the residents' wishes. but can't waste time before starting [CPR] .We [the facility's administrative staff] will need to discuss this in QAPI . The Medical Director stated the staff had received education and in-services .but they forget . the training. The Medical Director confirmed additional training of staff and a discussion needed to be conducted during QAPI to discuss strategies regarding codes and CPR. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:30 AM, the Administrator stated codes (Code Blue) and residents who received CPR were discussed in the daily meetings after the events occurred. The Administrator stated she was not aware untrained staff had performed CPR and agreed she should have known or been made aware. The Administrator stated she believed the facility had an effective QAPI program until learning of staff performing CPR who were not certified or trained, staff having intentions on performing CPR who were not certified or trained, and staff not being aware of the code book location in the event of emergencies. The Administrator confirmed she was not aware the CPR documentation completed after the code events did not contain all the required information on all staff who participated or performed CPR. The Administrator confirmed further education and communication were needed to prevent recurrence. During an interview on [DATE] at 12:15 PM, the Clinical Resource Director stated he had been employed with the company for approximately 1 month (date of hire was [DATE]). The Clinical Resource Director stated he had attended QAPI meeting and had not been made aware CPR had been performed on 3 residents from ,d+[DATE]-,d+[DATE] by staff who were not certified in CPR. The Clinical Resource Director stated he and the QAPI committee should have known and agreed staff needed further education. The Clinical Resource Director stated he expected staff who performed CPR be trained and certified in CPR before performing the life sustaining measures. An acceptable removal plan for F-867 was received on [DATE] at 9:48 PM. Validation of the Removal Plan to remove the immediacy of the Jeopardy (IJ) was conducted on [DATE] through review of facility documentation, medical records, and interviews. The removal plan for F-867 dated [DATE] as follows: Failure to honor Resident #3's wishes for end-of-life treatment and accurately reflecting Do Not Resuscitate in medical record: Resident #3 was transferred to the hospital on the date of the incident ([DATE]) and returned to the facility on [DATE]. Upon return to the facility, Medical Records and Licensed Nurses re-verified her preference related to resuscitation and obtained a physician's order for DNR (Do Not Resuscitate). Since code status is applicable to all residents, Medical Records, under the direction of the Administrator, audited all residents' POST forms (or absence thereof) and verified that the Physicians' Orders in the EMR matched what was on the POST forms. This audit was completed on [DATE]. No discrepancies were identified during the audit. Ad hoc QAPI meeting held at 4:00 PM on [DATE]. Purpose to discuss and review all IJ templates and removal plan. Members present included the Medical Director, Administrator, DON, Governing Body, RN Charge nurse, ADON, and MDS nurse. QAPI meetings on [DATE] and [DATE] resulted in the following: -On [DATE] the Code Blue binder changed to a bright blue binder to ensure staff would recognize during code blue event. (continued on next page)

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