STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015134	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birmingham Nursing and Rehabilitation Center East	733 Mary Vann Lane Birmingham, AL 35215

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, and review of a facility reported incident, the facility failed to ensure Resident Identifier (RI) #58, a resident with moderate cognitive impairment, was assessed for self-administration of medication before Licensed Practical Nurse (LPN) #13 gave RI #58 a rectal suppository for RI #58 to self-administer on 12/06/2023. This affected RI #58, one of 10 residents for whom medications were reviewed. Findings include: On 12/07/2023 the facility reported to the Alabama Department of Public Health Online Incident Report System an incident involving RI #58 in which RI #58's Resident Representative alleged negligence due to RI #58 being handed a suppository by LPN #13 for RI #58 to self-administer on 12/06/2023. RI #58 was re-admitted to the facility on [DATE] with diagnoses to include: Schizoaffective Disorder (Bipolar Type) and Parkinson's Disease. RI #58's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 09/08/2023 documented a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated RI #58 had moderate cognitive impairment. On 05/07/2024 at 11:26 AM RI #58 was asked about the incident that occurred on 12/06/2023. RI #58 said, he/she asked the nurse for a suppository and the nurse gave one to RI #58 for the resident to self-administer, even though RI #58 had not been administering his/her own medications and RI #58 had not received any education on administering the suppository. On 05/09/2024 at 11:09 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked about the system the facility had in place to determine a resident's safety in self-administration of medications. The DON said, they evaluated residents based on their BIMS scores for cognitive status. The DON said, the doctor would also have to sign an order for the resident to self-administer medication, and RI #58 did not have a physician's order for that. The DON said, RI #58 had not been assessed and approved for self-administration. The DON said, the nurse left the suppository with the resident and in doing so you would not know what the resident had done with the medication, it could have been dropped on the floor, flushed down the toilet, or could result in a medication error.

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review, FUNDAMENTALS OF NURSING NINTH EDITION, a complaint received by the Alabama Department of Public Health, the facility's policies titled RESIDENT BILL OF RIGHTS, ADVANCE DIRECTIVES, and Cardio Pulmonary Resuscitation (CPR), the facility failed to honor Resident Identifier (RI) #159's Advanced Directive for end-of-life wishes. RI #159 had an Advanced Directive which directed staff to withhold resuscitative measures in the event of cardiopulmonary cessation and an active physician's order for DNR (Do Not Resuscitate) code status. During the evening shift on [DATE], RI #159 was found unresponsive by Certified Nursing Assistant (CNA) #8 around 8:20 PM. The first licensed responder, Registered Nurse (RN) #9 did not check RI #159's code status in accordance with the facility's protocol before she initiated CPR. In addition to RN #9, the CPR Instructor (INST), Licensed Practical Nurse (LPN) #11, and RN #12 participated in the code without verifying RI #159's medical record for an Advance Directive. The facility staff performed CPR for approximately ten minutes and then emergency medical services (EMS) arrived and took charge of the code. LPN #7 identified that RI #159 had Advance Directive for DNR, but first brought other documents to the room and resuscitative efforts continued until LPN #7 presented the Do Not Resuscitate (DNR) Order and EMS obtained authorization to discontinue CPR. RI #159 expired at 2116. As a result of initiating CPR and activating EMS, RI #159 was subjected to manual chest compressions, chest compressions with LUCAS Device (a mechanical chest compression device), endotracheal intubation, intravenous (IV) insertion, and intraosseous (IO) access insertion during the resuscitation efforts. This deficient practice placed RI #159, one of two sampled residents reviewed for Advance Directives, in immediate jeopardy, as the failure of facility staff to honor a resident's end-of-life wishes was likely to cause serious injury, serious harm, or serious impairment at RI #159's end-of-life. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, or impairment to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.10 Resident Rights at a scope and severity of J. On [DATE] at 10:57 PM, the Administrator and DON were provided a copy of the immediate jeopardy template and notified of the findings at the immediate jeopardy level in the area of Resident Rights at F578-Request/Refuse/Discontinue Treatment/Formulate Advance Directives. The IJ began on [DATE] and continued until [DATE] when survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F 578 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of complaint/report number AL00047231. Findings include: (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the Alabama Department of Public Health received a complaint from an anonymous source that alleged that a full code was performed on a resident with a Do Not Resuscitate (DNR) order. The complainant identified the resident as RI #159. FUNDAMENTALS OF NURSING NINTH EDITION, with a copyright date of 2017, Chapter 23, titled Legal Implications in Nursing Practice, page 305, documented: . Advance Directives include living wills, health care proxies, and durable powers of attorney for health care . They are based on values of informed consent, patient autonomy over end-of-life decisions, truth telling, and control over the dying process . Health care providers perform CPR when needed unless there is a DNR order . The facility's RESIDENT BILL OF RIGHTS with most recent history date of 01/2023 documented: Each resident has a right to a dignified existence, self-determination . regardless of diagnosis, severity of condition . A. Facility resident shall have the right to: .6. Request, refuse and/or discontinue treatment . 29. Formulate advanced directives . The facility policy titled ADVANCE DIRECTIVES with a most recent history date of 08/2017 documented: POLICY: It is the policy of the Facility to respect the resident's right of self-directed care including the right to issue Advance Directives on health care, to refuse . treatment . The facility's policy titled Cardio Pulmonary Resuscitation (CPR), with a revised date of 11/17, documented: POLICY: CPR will be instituted on all residents without a DNR or Advanced Directives identified. .PROCEDURE: 1. Upon admission, the Social Worker reviews the residents' Advanced Directives and initiates action to secure a DNR order, if appropriate. 2. Do Not Resuscitate (DNR) can be listed . so that each resident's wishes in this regard are known to all involved staff ." RI #159 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #159 had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Type Two Diabetes Mellitus with Diabetic Neuropathy, Hepatic Failure, and Congestive Heart Failure. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A form titled Alabama Portable Physician Do Not Attempt Resuscitation Order, No/CPR/Allow Natural Death was labeled with RI #159's name revealed: . Instructions. This order is valid only if Section I, II, III, OR IV is completed AND a physician has completed Section V . Section II. Incompetent Patient/Resident with DNAR instructions in Advances Directives. The patient/resident is not competent or is no longer able to understand, appreciate, and direct his/her medical treatment and has no hope of regaining that ability. A duly executed Advance Directive for Health Care with instructions that no life sustaining treatment be provided was previously authorized by the patient/resident and is part of his/her medical record . (signed by Licensed Baccalaureate Social Worker (LBSW) #22) . Date [DATE] . Section V. Physician Authorization Based on the information above, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold resuscitative measures, i.e., cardiopulmonary resuscitation, chest compressions, endotracheal intubation . in the event of cardiopulmonary cessation in the patient/resident. I further direct the implementation of all reasonable comfort care . to provide comfort and alleviate suffering by the patient/resident . (signed by physician) . Date [DATE] . A Social Service note for RI #159 dated [DATE] at 1:15 PM documented that RI #159 .is DNR . signed by Licensed Social Worker (LSW) #20. A Nursing note for RI #159 dated [DATE] at 6:11 PM documented: .I want to die! I can't go on any longer . I know it sounds sad, but I have been dealing with this for several years now, and its not going to get better . A second document signed by RI #159's designated HCP on [DATE], documented: . I, the undersigned, am the surrogate certified to make decisions, in consultation, with the attending physician, regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/resident. After consultation with the attending physician, I hereby direct that resuscitative measures be withheld from the patient/resident in the event of cardiopulmonary cessation. I believe this decision conforms as closely as possible to what the patient/resident would have wanted .(signed by RI #159's HCP) Section V. Physician Authorization Based on the information above, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold resuscitative measures, i.e., cardiopulmonary resuscitation, chest compressions, endotracheal intubation . in the event of cardiopulmonary cessation in the patient/resident. I further direct the implementation of all reasonable comfort care . to provide comfort and alleviate suffering by the patient/resident . (signed by Physician #21) Date [DATE] . (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	"A Physician's Telephone Order for RI #159 documented DNR and was signed by Physician #21 on [DATE]. Review of RI #159's [DATE] PHYSICIAN ORDERS, revealed an order dated [DATE] for . Status . DNR . The facility timeline dated [DATE] for RI #159 documented that the resuscitation efforts began around 8:20 PM. A Nursing note for RI #159 dated [DATE] 12:01 AM " . Resident found unresponsive per CNA code was called EMS activated charge nurse noted resident to be DNR all life saving measures stopped EMS pronounced deceased at 2116 . documented by LPN #7. The EMS run report, dated [DATE], indicated the facility contacted EMS on [DATE] at 8:35 PM. EMS arrived to RI #159 at 8:43 PM. The Narrative Section documented the following: . DISPATCHED TO CARDIAC ARREST . STAFF AT (HIS/HER) SIDE PROVIDING CPR . ASKED NURSE TO CONFIRM PATIENT WAS NOT A DNR AND WAS TOLD "NO HE IS A FULL CODE" . CONTINUED CPR USING LUCAS. INTIATED IO (Intraosseous Access) TO RT HUMEROUS AND CONNECTED NS AT BOLUS. PATIENT INTUBATED . MEDS AND DEFIB ADMINISTERED . PATIENT INITIAL RHYTHM ASYSTOLE THEN TO V-FIB. WHILE WORKING CARDIAC ARREST NURSE WALKED IN AND PRODUCED A SIGNED DNR FOR THE PATIENT. CONTACTED MED CONTROL . RECEIVED ORDERS TO TERMINATE CPR. TIME OF DEATH 2116 (9:16 PM) . " On [DATE] at 10:39 AM an interview was conducted with CNA #8. She said on [DATE] she went to RI #159's room and saw he/she was looking pale, and he/she just mumbled so she went to get help. CNA #8 stated she ran to the next unit and asked RN #9 to check RI #159. She stated RN #9 told her to call a Code Blue. She stated she went to North Hall to find nurses and the nurses already had the crash cart. CNA #8 stated she saw RN #9, the INST, LPN #11, and RN #12 were in RI #159's room while CPR was being performed. She stated LPN #7 did not perform CPR; however, during the code LPN #7 told staff that RI #159 was a DNR. During an interview with RN #9 on [DATE] at 5:30 PM she stated that she was not assigned to RI #159 on [DATE] and she was not the supervisor. RN #9 said a CNA asked her to check on RI #159 because he/she did not appear to be breathing and the nurse assigned to RI #159 had stepped out. She stated she ran over to assist and when she entered the room RI #159 had agonal breaths, so she initiated CPR and called the Code. RN #9 said she performed CPR for six to seven minutes by herself. RN #9 said she did not check RI #159's code status before she initiated CPR. RN #9 said 30 to 45 minutes later it came up that RI #159 had DNR code status. RN #9 said she did not know RI #159's code status while providing CPR. RN #9 said at time of the incident, residents with a DNR order were identified in their charts and the oncoming nurse should have received report about residents with DNR code status. RN #9 was asked, what was the concern with performing CPR on a resident who had DNR code status. RN #9 said when the second nurse appeared on the scene, the second nurse should have asked what was needed and hopefully checked the chart for code status. RN #9 said the residents' wishes were not honored when CPR was performed on a resident with DNR code status. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:30 PM an interview was conducted with CNA #10, CPR INST/Staffing Coordinator. The INST stated that on [DATE] at an unknown time, but after dark, RI #159 was found unresponsive by CNA #8. He said CNA #8 came to through the doors screaming for help and said something was wrong with RI #159. The INST stated that RN #9 arrived first to RI #159's room. The INST stated he applied a pulse oximetry, and the reading was zero and then RN #9 started compressions. The INST stated he went to nurses' station and called a code overhead on intercom. The INST stated that North Wing nurses, RN #12 and LPN #11, came and assisted with CPR. The INST said LPN #7 arrived at room and asked if 911 was called and CNA #8 said yes. The INST stated that when the paramedics arrived all the staff left the room. The INST said LPN #7 produced an Advanced Directive for DNR, but it was actually a Power of Attorney (POA) document. The INST said since the POA document was not a DNR EMS continued CPR. The INST said when LPN #7 found the signed Advanced Directive for DNR and showed it to EMS, all lifesaving efforts were stopped. On [DATE] at 9:22 AM an interview was conducted with LPN #11 who was working on [DATE]. LPN #7 stated that on [DATE] he was working on the North Wing adjacent to South Wing when he heard CNA #8 scream Code Blue. He stated that RN #12 and he responded to RI #159's room. He stated when he entered the room, RN #9 was performing chest compressions and he took over compressions. LPN #11 said RI #159 was not showing any signs of life. LPN #11 said he did not check RI #159's code status and had assumed the nurse who started CPR had checked RI #159's code status. LPN #11 said EMS arrived at the resident's room after facility staff performed CPR for about ten minutes. LPN #11 said as was leaving RI #159's room, LPN #7 came to the room and said RI #159 had DNR code status. LPN #11 said per the facility's policy for CPR and Advanced Directives, all residents were admitted with Full Code status unless a portable DNR was signed and when a resident was found with absence of life staff performed CPR accordingly. LPN #11 said he did not know if the policy was followed when CPR was provided to RI #159. LPN #11 said he never looked in RI #159's chart. LPN #11 said it went against the resident's wishes and the physician's orders when staff performed CPR on a resident was who had an Advanced Directive for DNR. On [DATE] at 10:11 PM an interview was conducted with LPN #7, former Charge Nurse. She was asked to explain what occurred during on [DATE]. LPN #7 stated she had counted the medication cart with LPN #13 who had been assigned to RI #159 because she was getting off work at 8:00 PM. LPN #7 stated she went on break and out to her car. She stated when she came inside RI #159 was being coded and in the room was RN #9, RN #12, LPN #11, and the INST. She stated she checked RI #159's chart and noted he/she was a DNR and went to the room to let the staff know. LPN #7 stated she never performed CPR on RI #159 but did tell them to stop. During a follow-up interview with LPN #7 on [DATE] at 1:26 PM, LPN #7 said the facility had not provided any training to staff on the facility's procedures to implement Advance Directives, but she thought every nurse should know to check the chart to verify a resident's code status before initiating CPR. LPN #7 said on [DATE], when she returned from outside, she saw that RI #159 was being coded. She said she went to the nurses' desk saw that RI #159's chart had a sticker that indicted he/she had DNR orders. LPN #7 said she found RI #159's Advanced Directive for DNR and took it to the room, but the staff did not stop providing life-saving measures because it was dated 2022. LPN #7 said she went back to the chart and found the most recently dated Advanced Directive for DNR and took it to the room. LPN #7 said shortly after she produced the second Advanced Directive, the resuscitation efforts were stopped. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on [DATE] at 11:08 AM, she said per the facility's policy on CPR/Advance Directives, CPR was to be performed according to the physician's orders. The DON said upon admission resident was either a full code or DNR. She stated that the facility had to have a portable DNR consent signed by the physician, and it must be in the chart. The DON said it must also be signed by the resident/resident representative. The DON stated the policy was not followed when RI #159 was coded when he/she should not have. The DON said RN #9, LPN #11, and RN #12 performed CPR on RI #159, but she did not know how long CPR was provided. The DON said the first responding licensed staff should have checked the resident and then checked the chart to find the resident's code status. When asked what the concern with performing CPR on a resident had a DNR code status she stated it was an error, it should not have been done, and staff must follow orders at all times. The DON said it would be devastating if someone performed CPR on a loved one that had DNR code status. During an interview with ADM on [DATE] at 12:17 PM she said the facility's policy on CPR/Advanced Directives was that CPR would be instituted on all residents without a DNR or Advanced Directives identified. The ADM said the policy was not followed when staff provided CPR to RI #159. The ADM was asked whether staff had been trained for response or had the facility conducted mock codes and she replied that it was not a routine in-service. The ADM was asked, what should staff do when a resident was found unresponsive. The ADM replied that she could not speak for staff. The ADM said the concern with staff performing CPR on a resident who was a DNR was not following the physician's orders. During a follow-up interview with the DON on [DATE] at 6:41 PM she was asked what were staff expected to do when a resident had a decline in condition that might warrant CPR and she stated staff should check the resident, call out for assistance, and check the resident's code status. The DON said if the resident had full code status then staff should announce or call the code, call 911, and initiate CPR. The DON said she did not know why that was not done for RI #159. The DON was asked what happened when an IO was inserted and when a [NAME] device was used; the DON stated an IO was inserted into the bone to administer medications, fluids, and obtain bloodwork. The DON stated the [NAME] device was to deliver mechanical compressions and could have resulted in broken ribs from the compressions. The DON said the resuscitation efforts provided to RI #159 could have resulted in broken ribs from chest compression and the defibrillation and intubation could have kept RI #159 alive against his/her wishes. An interview was conducted with the Nurse Practitioner (NP) on [DATE] at 10:24 AM. The NP was stated she was aware of the incident involving RI #159. She stated the facility's policy was that the DNR must be signed by the physician and the family. She stated if a resident was a DNR staff should follow the resident's wishes. When asked what the facility's policy was on CPR/Advanced Directives she responded residents' wishes must be followed. When asked was the policy followed in the case of RI # 159, she replied no. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:34 PM RI #159's Health Care Proxy (HCP) and family member, was interviewed. The HCP confirmed that RI #159 had an Advanced Directive for DNR, which was consistent with RI #159's end-of-life wishes. The HCP said she was informed by RN #9 on the phone that resident was found unresponsive, and that CPR was being performed. During the code she stated she recognized the voice of LPN #7 screaming that he/she was a DNR and they would not stop. The HCP stated that LPN #7 told her the staff coded RI #159 for 45 minutes. The HCP stated it made her feel terrible that CPR was performed on RI #159, and she was upset because she knew they were beating on him/her. The HCP said RI #159 knew how sick he/she was and did not want to subjected to CPR. The HCP stated that CPR should not have been performed because RI #159 had DNR code status in accordance with both of their wishes. The HCP said it was hard seeing RI #159 after the resuscitation efforts, and she saw bruises on RI #159's chest. ************************* The facility took immediate actions to correct the non-compliance and prevent reoccurrence by: 1. Emergency Quality Assurance committee meeting held to review and approve deficiency action plan for F 578 and the dot sticker system to identify code status. 2. Medical Director notified of IJ deficiencie: F 578 3. All residents with Do Not Resuscitate (DNR) orders have the potential to be affected, the facility completed 100% code status audit to ensure each resident's code status verified. This was completed by the ED, DNS, Clin-ops, on [DATE]. 4. The chart spine will have an orange sticker placed stating DNR and an orange dot on the name tag on the resident's door to indicate DNR status; also, a green sticker stating FULL CODE will be placed on the spine of the chart and a green dot on the name tag of the resident's door to indicate FULL CODE status. 5. This will allow for easy verification of residents who have chosen DNR status. DNR wishes will be easily recognized by any staff member without having to go to the medical record or the resident's care plan. 6. ED, DNS and Clin-ops will in-service 100% of staff on the dot/sticker system on [DATE]. No staff member will be allowed to return to work until in-service complete. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, interviews, the facility investigative file for Resident Identifier (RI) #400, and a facility policy titled Abuse Prevention, the facility failed to ensure RI #400 was free from misappropriation of property when the facility was unable to account for 34 doses of RI #400's Hydrocodone-Acetaminophen Oral Tablet 5.0-325 milligrams (mg). The facility further failed to ensure the residents on the Transitional Care Unit (TCU) were free from misappropriation when Licensed Practical Nurse (LPN) #5 took medications from the TCU medication cart. This had the potential to affect RI #400, one of three residents sampled for abuse and all residents residing on the TCU. This deficiency was cited as a result of the investigation of facility reported incident/complaint/report number AL00048045. Findings include: Review of a facility policy undated titled ABUSE PREVENTION, documented . POLICY: . The facility is committed to protecting the residents from abuse . DEFINITIONS: . Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. On 05/31/2024 the State Agency received an Online Incident Report from the facility alleging staff was unable to locate RI #400's medication card containing 30 tablets of Hydrocodone-Acetaminophen (controlled medication), four tablets were missing from RI #400's medication card of 60 Hydrocodone-Acetaminophen, the cost of these unaccounted medications was to be credited to the resident's account after staff attempted to find the medications unsuccessfully, and LPN #4 and LPN #5 were placed on suspension pending investigation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Birmingham Nursing and Rehabilitation Center East		STREET ADDRESS, CITY, STATE, ZIP CODE 733 Mary Vann Lane Birmingham, AL 35215	

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigative file for RI #400 was reviewed and an undated document was reviewed and revealed the following: . On 5/27/2024 it was noted by (LPN #5) that the narcotic sign out log was not original and had been reconstructed. it was noted that Norco 5mg (milligram) belonging to (RI #400) 30 tablet blister pack card was missing. The original prescription that was (dispensed) from pharmacy was Norco 5/325 mg, 90 tablets sent in a blister pack of 60 tablets and a blister pack of 30 tablets to total 90 tablets. It was apparent the original narcotic count sheet was being utilized until 5/28/2024. Then after this date the narcotic sheet . was recreated by (LPN #4) with a starting count of 55 tablets . does not match number used according to the MAR. Nurse (LPN #4) admitted to recreating the narcotic count sheet and admitted to the original being present at beginning of her shift. Nurse denies knowledge of knowing what happened to the original narcotic count sheet. Admits to recreating the narcotic count sheet and admits she did not (notify) a supervisor of missing narcotic count sheet. (LPN #4) suspended pending investigation on 5/28/2024. internal security camera recordings watched and appeared to show employee removing narcotic sheet and placing them in a plastic bag then placing into her personal back pack. The shred boxes throughout the facility and garbage cans were searched without success of finding the missing narcotic sign out sheet. While reviewing security camera recordings it was noted that Nurse . (LPN #5), was appearing to take and consume medication from the med cart during her shift. both of the practices that these nurses admitted too is a failure of facility policy, and not usual behaviors. Both Nurse (LPN #4) and (LPN #5) was terminated on June 3, 2024 due to improper conduct. RI #400 was originally admitted to the facility on [DATE]. A review of RI #400's Physician's Orders for May 2024 revealed Hydrocodone-Acetaminophen Oral Tablet 5. 0-325 milligrams (mg) was ordered for pain on 05/02/2024 and 05/04/2024 to be administered every six hours as needed, and was discontinued on 05/30/2024. RI #400's EMAR dated 05/2024 documented RI #400 had received only a total of seven (7) doses of Hydrocodone-Acetaminophen 5.0-325 mg Oral Tablet for pain between 05/02/2024 and 05/06/2024. There was not any documentation on the EMAR of doses given after 05/06/2024. On 07/11/2024 at 4:29 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) #5 and she was asked about the incident with a handwritten controlled drug record for RI #400. LPN #5 said, on Monday 05/27/2024 when she went to give RI #400 medication there was a card of 30 missing, four tablets missing from the card of 60 Norco, and there was a handwritten sheet signed by LPN #4, like what would be used if recieving medication from the backup pharmacy. When asked if the facility was able to determine where the missing medication went, LPN #5 said, she did not know because she quit when they began questioning her about the camera footage of her taking medicine off the cart and placing it in her bag. LPN #5 said, it was Tylenol and Melatonin that she took from the medication cart and placed in her bag. On 07/11/2024 at 05:01 PM, interview with Director of Nursing (DON) stated she was notified of missing medication on 05/28/2024 by LPN #5. The DON said, she was initially made aware of a 30-count card of Norco missing for RI #400, an investigation was started, and controlled medicaitons were checked. When asked about the handwritten controlled drug record, the DON stated, the nurse should have notified the supervisor or DON prior to making the handwritten sheet. The DON said, she was not notified of the need for a new sheet. The DON was asked if it was routine or standard of nursing practice. DON said, no. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birmingham Nursing and Rehabilitation Center East	733 Mary Vann Lane Birmingham, AL 35215

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/11/2024 at 5:49 PM, the Pharmacist was asked what would be the reason a nurse would take cups of medicine from a medication cart and put in a personal bag. The Pharmacist said, trying to divert medicine. When asked what the concern would be of a nurse placing medication in a personal bag. The Pharmacist replied, he could not think of a legitimate reason for that. On 07/11/2024 at 9:30 PM, interview with Former Assistant Director of Nursing, was asked, what would be the reason a nurse would take cups of medicine from a medication cart and put in his/her personal bag. She said, there was not a reason for that to occur. She was asked, what was the concern of this practice. She replied, very concerning, it looked and felt odd, like something was being done illegal. On 07/11/2024 at 9:42 PM in an interview with the Clinical Operations Nurse she was asked about the two LPNs terminated. She said, LPN #4 was observed on camera discarding and recreating a new controlled narcotic medication sheet without notification to the supervisor or Director of Nursing. She said, LPN #4 did not report the missing controlled narcotic medication record and took it upon herself to create another one. She said LPN #5 was related to suspicious activity observed by video surveillance removing something from the medication cart and placing it in her bag.

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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 - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, a complaint recieved by the Alabama Department of Public Health, and the facility policy titled Cardio Pulmonary Resuscitation (CPR) the facility failed to ensure CPR was not initiated for Resident Identifier (RI) #159 on [DATE]. RI #159 had an Advanced Directive directing staff to withhold lifesaving measures including CPR. On [DATE] at approximately 8:20 PM, RI #159 was found by Certified Nursing Assistant (CNA) #8 in respiratory distress, mumbling and appeared pale in color. CNA #8, notified Registered Nurse (RN) #9 who responded and found RI #159 to be unresponsive to sternal rub. RN #9 initiated CPR and instructed CNA #8 to call a Code Blue and summon additional assistance from facility staff. RN #12, RN #9, Licensed Practical Nurse (LPN) #11 and the CPR Instructor (INST) assisted during the code and did not check RI #159's code status. The facility staff performed CPR for approximately 10 minutes until Emergency Medical Services (EMS) arrived at 8:43 PM. EMS provided Advanced Cardiac Life Support until LPN #7 informed them that RI #159 had an Advance Directive for Do Not Resuscitate and presented the documentation. RI #159 expired at 9:16 PM. The resuscitation efforts included manual chest compressions, chest compressions with LUCAS Device (a mechanical chest compression device), endotracheal intubation, intravenous (IV) insertion, and intraosseous (IO) access. This affected RI #159, one of two residents reviewed for CPR. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, or impairment to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.24 Quality of Life at a scope and severity of J. On [DATE] at 10:57 PM, the Administrator and DON were provided a copy of the immediate jeopardy template and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Quality of Life, at F678-Cardio-Pulmonary Resuscitation (CPR). The IJ began on [DATE] and continued until [DATE] when survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F 578 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. In addition to the deficient practice above, the facility failed to ensure all pertinent information, including time CPR was initiated, related to the resuscitation efforts were documented in the medical record and that LPN #11, a staff who provided CPR to RI #159, had current CPR certification. These deficient practices were cited as a result of the investigation of complaint/report number AL00047231. Findings include: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the State Survey Agency received an anonymous complaint from a former staff member who alleged that a full code was performed on a DNR (Do Not Resuscitate) resident (RI#159) a few months ago. She further alleged that it had come to her attention that several of the nurses were not CPR (Cardiopulmonary Resuscitation) certified when she worked there. The facility's policy titled Cardio Pulmonary Resuscitation (CPR), with a revised date of 11/17, documented: POLICY: CPR will be instituted on all residents without a DNR or Advanced Directives identified . RESPONSIBILITY: Licensed Nurses/CMT/Respiratory Therapist PROCEDURE: . 2. Do Not Resuscitate (DNR) can be listed . so that each resident's wishes in this regard are known to all involved staff ." 3. 911 is called. 4. Once code status is verified, CPR certified staff member on the scene initiates cardiopulmonary resuscitation. 5. The licensed staff members/CMT on the scene is responsible for documenting all pertinent information related to the event such as time, resident response, etc. 8. The Nursing Supervisor/Unit Manager/Charge Nurse oversee the resuscitation event, and that documentation is made in the medical record . RI #159 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #159 had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Type Two Diabetes Mellitus with Diabetic Neuropathy, Hepatic Failure, and Congestive Heart Failure. RI #159's medical records included Advanced Directives dated [DATE] and [DATE]. The Advanced Directives indicated RI #159 had Do Not Resuscitate code status. "A Physician's Telephone Order for RI #159 documented DNR and was signed by Physician #21 on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of RI #159's [DATE] PHYSICIAN ORDERS, revealed an order dated [DATE] for . Status . DNR . A nurses note dated [DATE] 12:01 AM entered by LPN #7 indicated that RI #159 was found unresponsive, and a code was called and EMS was activated. The EMS run report, dated [DATE], indicated the facility contacted EMS on [DATE] at 8:35 PM. EMS arrived to RI #159 at 8:43 PM. The Narrative Section documented the following: . DISPATCHED TO CARDIAC ARREST . STAFF AT (HIS/HER) SIDE PROVIDING CPR . ASKED NURSE TO CONFIRM PATIENT WAS NOT A DNR AND WAS TOLD "NO HE IS A FULL CODE" . CONTINUED CPR USING LUCAS. INTIATED IO (Intraosseous Access) TO RT HUMEROUS AND CONNECTED NS AT BOLUS. PATIENT INTUBATED . MEDS AND DEFIB ADMINISTERED . PATIENT INITIAL RHYTHM ASYSTOLE THEN TO V-FIB. WHILE WORKING CARDIAC ARREST NURSE WALKED IN AND PRODUCED A SIGNED DNR FOR THE PATIENT. CONTACTED MED CONTROL . RECEIVED ORDERS TO TERMINATE CPR. TIME OF DEATH 2116 (9:16 PM) . " The facility timeline of the incident documented that on [DATE] around 8:15 PM CNA #8 entered RI #159's room and noted his/her breathing was shallow and his/her color had changed. At 8:20 PM CNA #8 exited the room hollering for help and RN #9 and the INST responded. RN #9 observed that RI #159 was in distress and began chest compression. The INST called the Code Blue. There were five individuals assisting in the code, RN #12, RN #9, LPN #7, LPN #11 and the INST. At 9:16 PM RI #159 expired. During an interview with RN #9 on [DATE] at 5:30 PM she stated, she was asked to check on RI #159. She stated when she entered the room RI #159, did not appear to be breathing so she proceeded to perform CPR for six to seven minutes by herself until LPN #11, RN #12, and the INST assisted with CPR. RN #9 stated LPN #7 came to the room [ROOM NUMBER] to 45 minutes later with a signed DNR. RN #9 said she did not check RI #159's code status before initiating CPR. During an interview on [DATE] at 5:30 PM with the INST, he stated he was working the evening of [DATE] when RI #159 was found unresponsive by CNA #8. The INST stated RN #9 was the first to arrive and RN #9 started compressions. INST stated he called a code overhead and EMS was called. INST stated that RN #12 and LPN #11 came and assisted with CPR. During an interview with LPN #11 on [DATE] at 9:22 AM the LPN stated that on [DATE] while working on the North Wing adjacent to South Wing, he heard CNA #8 scream Code Blue. He stated that RN #12 and he responded to RI #159's room. He stated when he entered the room RN #9 was already performing chest compressions, so he took over the compressions. When asked if he checked RI #159's code status he stated no, he assumed RN #9 had checked the code status. LPN #11 was asked what was the concern with performing CPR on a resident who was a DNR. LPN #11 replied, we went against the resident/family wishes and against MD orders. During an interview with LPN #11 on [DATE] at 8:55 AM, was asked was the certification in CPR on [DATE] current. LPN #11 stated, no and his CPR certification expired on [DATE]. On [DATE] at 10:06 PM an interview was conducted with LPN #7. She was asked to explain what occurred during the code on RI #159 on [DATE]. LPN #7 stated she went on break and out to her car. She stated when she came inside RI #159 was being coded in the room by RN #9, RN #12, LPN #11, and the INST. She stated she checked RI # 159's chart and noted RI #159 was a DNR and went to the room to let the staff know. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:39 PM an interview was conducted with the DON. The DON was asked what was the facility policy for CPR, she stated, staff member was to check resident's chart to see if resident was a full code or DNR. The DON said if resident was Full Code, then 911 was called and everyone who was available came to the code and first person started CPR. During an interview with the DON on [DATE] at 11:08 AM, she stated the policy was not followed for RI #159 because he should not have received CPR. When asked what the concern with performing CPR on a resident who was a DNR, she stated it should not have been done, it was an error, and staff must always follow orders. During an interview with the DON on [DATE] at 6:41 PM she was asked what are staff expected to do when a resident has a decline in condition that may warrant CPR and she stated staff should check the resident, call out for assistance, check the resident's code status and if full code call code, call 911, and initiate CPR. The DON said she did not know why that was done for RI #159. When asked if staff recorded the code on a CPR worksheet, she stated she could not locate the paperwork. The DON said an IO was inserted into the bone and the [NAME] device was to deliver mechanical compressions and could result in broken ribs from the compressions. On [DATE] at 12:56 PM a follow-up interview was conducted with the DON. The DON said facility staff should have used the CPR worksheet located on the crash carts to document the resuscitation efforts provided to RI #159 on [DATE], but did not. The DON said the time the code began, time 911 was notified, time compression, time of ventilations, time CPR certified staff on scene, time staff verified code status, time EMS arrived, time EMS took over the code, and time the code was stopped or time the resident was transported from the facility should be documented. The DON said without the documentation the facility did not know the pertinent times related to the code. During an interview with ADM on [DATE] at 12:17 PM, she was asked what was the facility's policy on CPR/Advanced Directives. She stated CPR would be instituted on all residents without a DNR or Advanced Directives identified. When asked, was the policy followed regarding RI #159, she stated, no it was not. On [DATE] at 12:17 PM a follow-up interview was conducted with the ADM. The ADM said the root cause of the incident was staff's failure to check RI #159's code status before initiated CPR. During an interview with RI#159's sister on [DATE] at 04:34 PM, the sister stated RI #159 was a DNR. She stated she was notified by the facility on the evening of [DATE] per RN #9 that RI #159 was unresponsive and was being coded at that time. She stated she could hear and recognize the voice of LPN #7 in the background telling the nurses that RI #159 was a DNR, but she could hear the code continuing. The sister stated that RN #9 called her an hour or more later to tell her that RI #159 did not make it. The sister stated, the next day she received a call from LPN #7, and she told her the staff coded RI #159 for about 45 minutes. The sister stated LPN #7 said they let her go and facility was in a tizzy to get everyone CPR certified. This deficient practice was cited as a result of the investigation of complaint/report number AL00047231. On [DATE] the facility submitted an acceptable Removal Plan for F 678 which documented: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	** 1. Emergency Quality Assurance committee meeting held to review and approve deficiency action plans F867, F578, F725, and F678 and the dot sticker system to identify code status. 2. Medical Director notified of IJ deficiencies: F867, F578, F726, F725 AND F678. 3. All residents with Do Not Resuscitate (DNR) orders have the potential to be affected, the facility completed 100% code status audit to ensure each resident's code status verified. This was completed by the ED, DNS, Clin-ops, on [DATE]. 4. An orange sticker was placed on the spine of the resident's chart stating DNR and an orange dot on the name tag on the resident's door to indicate DNR status; also, a green sticker stating FULL CODE was placed on the spine of the chart and a green dot on the name tag of the resident's door to indicate FULL CODE status. This was completed on [DATE] by medical records. The AED, DNS, and Clin-ops completed and audit of all resident's charts and doors to ensure charts and doors were properly marked with code status, on [DATE]. 5. This will allow for easy verification of residents who have chosen DNR status. DNR wishes will be easily recognized by any staff member without having to go to the medical record or the resident's care plan. 6. ED, DNS, and Clin-ops will in-service 100% of staff on the dot/sticker system on [DATE]. No staff member will be allowed to return to work until in-service complete. 7. ED, DNS, and Clin-ops completed 100% audit of care plans to verify code status is care planned. This audit was completed [DATE]. 8. Development and implementation of a new policy titled Accident/Incident & Adverse Events to include feedback, documentation, and investigation of all resident accidents and adverse events. ************************ (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from [DATE] to [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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide sufficient nursing staff to consistently meet the needs of the residents. This deficient practice affected Resident Identifier (RI) #159. The facility failed to ensure the South Unit was properly staffed on [DATE] around 8:20 PM when RI #159 was found unresponsive by Certified Nursing Assistant (CNA) #8. Two nurses were scheduled to be working on the unit; however, one nurse left early after working nearly 15 hours that day and the other one was in the parking lot. The CNA left the unresponsive resident to summon nurses from another unit who responded by initiating Cardiopulmonary Resuscitation (CPR) without first checking RI #159's medical record for the DNR order that was in effect. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, or impairment to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.35 Nursing Services at a scope and severity of J. On [DATE] at 4:25 PM, the Administrator and DON were provided a copy of the immediate jeopardy template and notified of the findings at the immediate jeopardy level in the area of Nursing Services at F 725- Sufficient Nursing Staff. The IJ began on [DATE] and continued until [DATE] when survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F 725 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00047231. Findings include: RI #159 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #159 had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Type Two Diabetes Mellitus with Diabetic Neuropathy, Hepatic Failure, and Congestive Heart Failure. Review of RI #159's [DATE] PHYSICIAN ORDERS, revealed an order dated [DATE] for . Status . DNR . A review of a facility document indicated . staffing is based on acuity of our residents and census. We do not have a specific ratio. However, we have a pattern of staffing as follows: . Dayshift 6PM - 6AM South Unit = 1 Licensed Nurse . A review of the facility daily staffing schedule dated [DATE] indicated License Practical Nurse (LPN) #7 was scheduled for the 2:30 PM to the 10:30 PM shift, and LPN #13 scheduled from 6:30 AM to 10:30 PM on the South Unit. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facilities punch detail report dated [DATE] to [DATE] indicated, LPN #13 clocked in at 6:18 AM and clocked out at 8:23 PM. The facility timeline of the incident documented that on [DATE] around 8:15 PM CNA #8 entered RI #159's room and noted his/her breathing was shallow and his/her color had changed. At 8:20 PM CNA #8 exited the room hollering for help and Registered Nurse (RN) #9 and the CPR Instructor (INST)/Staffing Coordinator responded. RN #9 observed that RI #159 was in distress and began chest compressions. The INST called the Code Blue. There were five individuals assisting in the code, RN #12, RN #9, Licensed Practical Nurse (LPN) #7, LPN #11 and the INST. The timeline indicated that 911 was called at 8:30 PM. The EMS run report, dated [DATE], indicated the facility contacted EMS on [DATE] at 8:35 PM. EMS arrived to RI #159 at 8:43 PM. The Narrative Section documented the following: . DISPATCHED TO CARDIAC ARREST . STAFF AT (HIS/HER) SIDE PROVIDING CPR . ASKED NURSE TO CONFIRM PATIENT WAS NOT A DNR AND WAS TOLD "NO HE IS A FULL CODE" . CONTINUED CPR USING LUCAS. INTIATED IO (Intraosseous Access) TO RT HUMEROUS AND CONNECTED NS AT BOLUS. PATIENT INTUBATED . MEDS AND DEFIB ADMINISTERED . PATIENT INITIAL RHYTHM ASYSTOLE THEN TO V-FIB. WHILE WORKING CARDIAC ARREST NURSE WALKED IN AND PRODUCED A SIGNED DNR FOR THE PATIENT. CONTACTED MED CONTROL . RECEIVED ORDERS TO TERMINATE CPR. TIME OF DEATH 2116 (9:16 PM) . " On [DATE] at 10:39 AM an interview was conducted with CNA #8. She said on [DATE] LPN #8 told her that she was taking a break in her car. CNA #8 went to RI #159's room and saw he/she was looking pale, and he/she just mumbled so she went to get help. CNA #8 stated she ran to the next unit and asked RN #9 to check RI #159. She stated RN #9 told her to call a Code Blue. CNA #8 stated she saw RN #9, the INST, LPN #11, and RN #12 were in RI #159's room while CPR was being performed. She stated LPN #7 did not perform CPR; however, during the code LPN #7 told staff that RI # 159 was a DNR. During an interview with RN #9 on [DATE] at 5:30 PM she stated that she was not assigned to RI #159 on [DATE] and she was not the supervisor. RN #9 said a CNA asked her to check on RI #159 because he/she did not appear to be breathing and the nurse assigned to RI #159 had stepped out. She stated she ran over to assist and when she entered the room RI #159 had agonal breaths, so she initiated CPR and called the Code. RN #9 said she did not check RI #159's code status before she initiated CPR. RN #9 said 30 to 45 minutes later it came up that RI #159 had DNR code status. RN #9 said when the second nurse appeared on the scene, the second nurse should have asked what was needed and hopefully checked the chart for code status. RN #9 said the residents' wishes were not honored when CPR was performed on a resident with DNR code status. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Birmingham Nursing and Rehabilitation Center East		STREET ADDRESS, CITY, STATE, ZIP CODE 733 Mary Vann Lane Birmingham, AL 35215	

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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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:30 PM an interview was conducted with CNA #10, CPR INST/Staffing Coordinator. The INST stated that on [DATE] at an unknown time, but after dark, RI #159 was found unresponsive by CNA #8. He said CNA #8 came to through the doors screaming for help and said something was wrong with RI #159. The INST stated that RN #9 arrived first to RI #159's room and RN #9 started compressions. The INST said after EMS arrived, LPN #7 found the signed Advanced Directive for DNR and showed it to EMS, all lifesaving efforts were stopped. The INST was asked if he was responsible for the staffing by himself. He stated the Assisted Director of Nursing (ADON) staffed the nurses, and he staffed the Certified Nursing Assistance (CNA)'s. When asked how many staff should be on each shift, he stated it depended on patient ratio. He stated South Wing which had (38) residents would normally staff one nurse on dayshift. When asked if there was a concern with not having enough staff he said there had been a shortage of staffing and the facility pulled from administrative offices which used CNA's (housekeeping, medical records, maintenance, and Human Resources (HR)). He said they had to go and work on the floors. When asked what care was not being met because of low staffing he replied, sometimes meals would be passed later, and second and third shift would be less staffing. During an interview with DON on [DATE] at 6:41 PM, the DON was asked how many nurses were on the South Unit on [DATE] if one nurse had clocked out at 8:23 PM, and the other nurse was outside in her car. She said zero. When asked how many nurses were assigned to the South Unit for second shift on [DATE] she stated there were two. On [DATE] at 7:30 PM an interview was conducted with the Administrator (ADM). The ADM said following the facility's investigation LPN #7 was terminated for gross-negligence and performance duties. The ADM said the facility's Quality Assurance and Performance Improvement committee identified a concern with LPN #7 leaving her unit and going outside without telling another nurse. The ADM said no nurses were on the unit when LPN #7 went outside. ** On [DATE] the facility submitted the following acceptable removal plan. ** The facility took immediate actions to correct the non-compliance and prevent reoccurrence by: 1. Emergency Quality Assurance committee meeting held to review and approve deficiency action plans F 867, F 578, F 725, and F 678 and the dot sticker system to identify code status. 2. Medical Director notified of IJ deficiencies: F 867, F 578, F 726, F 725 and F 678. 3. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All residents with Do Not Resuscitate (DNR) orders have the potential to be affected, the facility completed 100% code status audit to ensure each resident's code status verified. This was completed by the ED, DNS, Clin-ops, on [DATE]. 4. An orange sticker placed stating DNR was placed on the spine of each resident's chart and an orange dot was placed on the doorway tag of the resident's room to indicate DNR status. A green sticker will be place on the spine of each resident's chart stating, FULL CODE and on the doorway name tag of the resident's room a green dot was placed to indicate resident as a full code. This was completed on [DATE] by medical records. ADE, DNS, and Clin-ops completed audit on all resident's chart and doors to ensure charts and doors were properly marked with code status, on [DATE]. This will allow for easy verification of residents who have chosen DNR. DNR wishes will be easily recognized by any staff member without having to go to the medical record or the resident's care plan. 5. ED, DNS, and Clin-ops will in-service 100% of staff on the dot/sticker system on [DATE]. No staff member will be allowed to return to work until in-service complete. 6. ED, DNS, and Clin-ops completed 100% audit of care plans to verify code status is care planned. This audit was completed [DATE]. 7. DNS will validate staffing for each day and each shift prior to the beginning of shift. DNS will be notified of any nonattendance of required shifts, such as (leaving early and sickness) to ensure replacement is obtained. 8. Development and implementation of a new policy titled Accident/Incident & Adverse Events to include feedback, documentation, and investigation of all resident accidents and adverse events. ** After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from [DATE] to [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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** Based on record review, interview, a facility document titled Code Blue Evaluation, and the facility CARDIOPULMONARY RESUSCITATION (CPR), the facility failed to ensure the facility provided training and skills verification to staff on their CPR policy. The facility did not implement training and skills verification to ensure all staff were able to respond to an emergent situation according to their policy to verify a resident's code status before initiating CPR. On [DATE] around 8:20 PM RI #159 was found unresponsive by Certified Nursing Assistant (CNA) #8. The staff who responded initiated CPR without first verifying Resident Identifier (RI) #159's code status in the medical record. Four staff members, Registered Nurse (RN) #12, RN #9, Licensed Practical Nurse (LPN) #11, and the CPR Instructor (INST) assisted during the code and did not check RI #159's code status. As a result of the staff failing to verify RI #159's code status, CPR was provided from approximately 8:20 PM until 9:16 PM. These failures affected RI #159, one of two residents reviewed for CPR and Advanced Directives. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, or impairment to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.35 Nursing Services at a scope and severity of J. On [DATE] at 4:25 PM, the Administrator and DON were provided a copy of the immediate jeopardy template and notified of the findings at the immediate jeopardy level in the area of Nursing Services at F726-Competent Nursing Staff. The IJ began on [DATE] and continued until [DATE] when survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F 726 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. The facility further failed to ensure Licensed Practical Nurse (LPN) #11 had current CPR Certification when he performed CPR; and the facility failed to ensure licensed staff documented the pertinent information related to the event. Findings Include: A review of facility policy titled CARDIOPULMONARY RESUSCITATION with an effective date of 11/2017 revealed POLICY: CPR will be instituted without a DNR or Advance Directive identified.Responsibility: Licensed Nurses . PROCEDURE: . 4. Once the code status is verified, CPR certified staff on the scene initiates Cardiopulmonary Resuscitation. 5. The licensed staff member on the scene is responsible for documenting all pertinent information related to the event such as time, resident response, etc. A review of staff's CPR certifications revealed the LPN #11 did not have current CPR certification. (continued on next page)

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F 0726

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

RI #159 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #159 had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Type Two Diabetes Mellitus with Diabetic Neuropathy, Hepatic Failure, and Congestive Heart Failure.

Review of RI #159's [DATE] PHYSICIAN ORDERS, revealed an order dated [DATE] for . Status . DNR .

The facility's document titled Code Blue Evaluation dated [DATE] at 10:55 PM documented that eight staff, including the CPR Instructor (INST), LPN #11, LPN #7, Registered Nurse (RN) #10, were evaluated using the form. The form indicated the location was the South unit. The form did not include any evaluation or criteria for staff to verify the resident's code status or check for Advanced Directives. The form indicated the initial assessment was not completed adequately due to slow nursing response. The form included check marks for Yes, No, or NA for the review criteria. No was checked for the following review criteria:

Initial Assessment Completed? .

Emergency Drug Box to area?

Code Leader Established? .

Were priorities anticipated and established?

Did all equipment operate properly?

Is Documentation complete?

Was CPR initiated and done correctly? .

The facility timeline of the incident documented that on [DATE] around 8:15 PM CNA #8 entered RI #159's room and noted his/her breathing was shallow and his/her color had changed. At 8:20 PM CNA #8 exited the room hollering for help and RN #9 and the INST responded. RN #9 observed that RI #159 was in distress and began chest compression. The INST called the Code Blue. There were five individual assisting in the code, RN #12, RN #9, LPN #7, LPN #11 and the INST. The timeline indicated that 911 was called at 8:30 PM.

The EMS run report, dated [DATE], indicated the facility contacted EMS on [DATE] at 8:35 PM. EMS arrived to RI #159 at 8:43 PM. The Narrative Section documented the following:

. DISPATCHED TO CARDIAC ARREST . STAFF AT (HIS/HER) SIDE PROVIDING CPR . ASKED NURSE TO CONFIRM PATIENT WAS NOT A DNR AND WAS TOLD "NO HE IS A FULL CODE" . CONTINUED CPR USING LUCAS. INTIATED IO (Intraosseous Access) TO RT HUMEROUS . PATIENT INTUBATED . MEDS AND DEFIB ADMINISTERED . WHILE WORKING CARDIAC ARREST NURSE WALKED IN AND PRODUCED A SIGNED DNR FOR THE PATIENT . TIME OF DEATH 2116 (9:16 PM) . "

During an interview with RN #9 on [DATE] at 5:30 PM she stated she was asked to check on RI #159. She said when she entered the room RI #159 appeared to be not breathing, so she proceeded to perform CPR for six to seven minutes. When asked if she checked RI #159's code status before initiating CPR, she replied no she did not.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:30 PM with the Staffing Coordinator/CNA/Instructor (INST), he said he was working the evening of [DATE] when RI #159 was found unresponsive by CNA #8. He said RN #9 was the first to arrive to RI #159's room and she started compressions and instructed CNA #8 to get the crash cart. He said he called a code overhead and EMS was called. He said as EMS was performing CPR, LPN #7 found a signed DNR, and returned to the room and showed it to the paramedics. Then all efforts of life saving were stopped. An interview was conducted on [DATE] at 9:22 AM with LPN #11. When asked what was RI #159's code status, LPN #11 said, when he entered RI #159's room, he saw nurse performing CPR and assumed code status had been checked. LPN #11 said he performed CPR on RI #159. An interview on [DATE] at 8:55 AM with the LPN #11 said his CPR certification expired on [DATE]. On [DATE] at 10:06 PM an interview was conducted with LPN #7. She was asked to explain what occurred during the code on RI #159 on [DATE]. LPN #7 stated after counting the medication cart around 8:00 PM, she went on break and out to her car. She said when she came inside RI #159 was being coded and in the room was RN #9, RN #12, LPN #11, and Staffing Coordinator/CNA. She said she checked RI #159's chart and noted he/she was a DNR and went to the room inform the staff. On [DATE] at 1:46 PM a follow-up interview was conducted with the DON. The DON was asked, what actions were taken before this incident to ensure all staff were aware of the facility's process for confirming code status and performance of CPR. The DON said they had a mock code and in-service on performance of CPR on [DATE]. On [DATE] at 7:30 PM an interview was conducted with the Administrator (ADM). The ADM was asked, how were staff educated on the CPR policy and resident rights upon hire. The ADM said CPR was not part of the Human Resources process, but she did ask for their CPR certification card. The ADM was asked, prior to the incident on [DATE], how were staff trained to perform CPR in accordance with residents' rights, advanced directives, and physician orders. The ADM said, staff were required to have CPR certification. The ADM said the facility's initial mock code was conducted on [DATE]. The ADM said after four staff provided CPR to a resident with an order for Do Not Resuscitate, the facility's investigation determined there was a problem with the facility's CPR training. The ADM said she was not aware until [DATE] that LPN #11 did not have current CPR certification on [DATE]. During an interview with RI #159's Responsible Party (RP) on [DATE] at 04:34 PM, she stated RI #159 was a DNR. She stated she was notified by the facility on the evening of [DATE] per Registered Nurse (RN) #9 that RI #159 was unresponsive and was being coded at that time. She stated she could hear and recognize the voice of LPN #7 in the background telling the nurses that he/she was a DNR, but she could hear the code continuing. ** On [DATE] the facility submitted the following acceptable removal plan. ** The facility took immediate actions to correct the non-compliance and prevent reoccurrence by: (continued on next page)

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Emergency Quality Assurance committee meeting held to review and approve deficiency action plans F 867, F 578, F 726, F 725, and F 678 and the new dot sticker system to identify code status. 2. Medical Director notified of IJ deficiencies: F 867, F 578, F 726, F 725 AND F 678. 3. All residents with Do Not Resuscitate (DNR) orders have the potential to be affected, the facility completed 100% code status audit to ensure each resident's code status was verified. This was completed by the ED, DNS, Clin-ops, on [DATE]. 4. An orange sticker placed stating DNR was placed on the spine of each resident's chart and an orange dot was placed on the doorway tag of the resident's room identified as DNR. A green sticker was placed on the spine of each resident's chart and on the doorway name tag of the resident's room identified as a full code. 5. This will allow for easy verification of residents who have chosen DNR. DNR wishes will be easily recognized by any staff member without having to go to the medical record or the resident's care plan. 6. ED, DNS, and Clin-ops will in-service 100% of staff on the dot/sticker system starting on [DATE]. No staff member will be allowed to return to work as of 11:59 PM tonight [DATE] until in-service complete. 7. ED, DNS, and Clin-ops completed 100% audit of care plans to verify code status is care planned. This audit was completed [DATE]. 8. The ED, DNS, and Clin-ops completed 100% audit of all licensed nurses CPR certification on [DATE]. No licensed nurse will be allowed to work at facility unless certified in CPR. ** (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implemented corrective actions including ongoing monitoring from [DATE] to [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, a review of the facility's pharmacy policy titled, CONTROLLED MEDICATIONS ADMINISTRATION, the facility failed to ensure controlled medication records were maintained, accurate, and without discrepancy to allow for accurate reconciliation for Resident Identifier (RI) #400. In May 2024 Licensed Practical Nurse (LPN) #4 signed controlled medication (Hydrocodone-Acetaminophen) for Resident Identifier (RI) #400 without documenting the administration of the medication on RI #400's Electronic Medication Administration Record (EMAR) 35 times. This deficient practice had the potential to affect RI #400 one of three sampled residents. Findings include: A facility policy titled CONTROLLED MEDICATIONS ADMINISTRATION last revised 08/2016 documented the following: . POLICY: . as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. PROCEDURE: . 6. When administering controlled medication, the authorized personnel records the administration on the MAR/eMAR and enters all of the following information on the Controlled Drug Record: a. Date and time of administration b. Amount administration c. Signature of the person preparing the dose d. Quantity reconciled 9. Any discrepancy in a controlled substance medication count is reported to the Director of Nursing immediately. 11.Controlled medications may be surrendered to a resident on pass or therapeutic leave or discharge if appropriate. The nurse and the resident and/or responsible party should record on the Controlled Drug Record the amount received, date, and time of release. RI #400 was originally admitted to the facility on [DATE]. A review of RI #400's Physician's Orders for May 2024 revealed Hydrocodone-Acetaminophen Oral Tablet 5. 0-325 milligrams (mg) was ordered for pain on 05/02/2024 and rewritten on 05/04/2024 to be administered every six hours as needed and was discontinued on 05/30/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of RI #400's Controlled Drug Records revealed LPN #4 signed out 38 doses of RI #400's Hydrocodone-Acetaminophen 5.0-325 mg Oral Tablets in May 2024. RI #400's May 2024 EMAR documented LPN #4 had administered only three doses of Hydrocodone-Acetaminophen 5.0-325 mg Oral Tablet for RI #400. On 07/11/2024 at 05:01 PM, the Director of Nursing (DON) was asked about the discrepancy in the number of controlled narcotics, Hydrocodone-Acetaminophen for RI #400. The DON was asked who was responsible for documenting on the EMAR. The DON replied, the nurse giving the medication. The DON was further asked what the concern was of not having the correct documentation on the EMAR. The DON replied, to ensure the resident had the most updated information and to ensure no discrepancy.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review, interview, and review of the Payroll Based Journal (PBJ) Report, the facility failed to report accurate staffing data from October 1, 2023 - December 31, 2023, to Centers for Medicare & Medicaid Services (CMS). This affected one quarter of data reviewed during the survey. Findings include: The PBJ report generated for the quarter of 10/01/2023 through 12/31/2023 documented .One star staffing Rating Triggered, and Excessively Low weekend Staffing Triggered . On 05/09/2024 at 4:06 PM, during an interview the the facility Executive Director/Administrator, she said, the human resources staff transmits the information pulled from the staff finger prints as they clock in, to the support office then the support office submits to CMS. She said, the report indicated low staff due to ancillary staff possibly not scanning if they worked as a Certified Nursing Assistant. She said, the one star indicated the facility could use more staff, however they had enough staffing to meet the needs for residents, but it did not pick up when the staff scanned in.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** Based on interviews, record review, and review of facility policies titled Quality Improvement Program, and Quality Assurance Performance Improvement Plan the facility's Quality Assurance Performance Improvement (QAPI) committee failed to systemically address all causal factors related to four staff providing Cardiopulmonary Resuscitation (CPR) to Resident Identifier (RI) #159, a resident with Advanced Directive for Do Not Resuscitate (DNR). The QAPI committee further failed to notify the Governing Body of the adverse event. On [DATE] RI #159's end-of-life wishes were not honored. Licensed staff failed to review RI #159's chart for code status prior to CPR. RI #159's nurse was not in the facility at the time of the code but was sitting outside in the car. When RI #159's nurse came onto the building during the code, she did try to review RI #159's record but could not readily and immediately locate the appropriate paperwork to identify RI #159's code status for DNR. All Licensed staff performing CPR on RI #159 did not have CPR certification that was current at that time. In response to the incident, the facility did not develop or implement an action plan to prevent recurrence. The failure of the QAPI committee to thoroughly review all factors and implement effective interventions following an adverse event had the potential to affect all 107 residents. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, §483.75 Quality Assurance and Performance Improvement at a scope and severity of L. On [DATE] at 10:57 PM, The Administrator (ADM) and the Director of Nursing, were provided a copy of the immediate jeopardy template and notified of the immediate jeopardy finding in the area of Quality Assurance and Performance Improvement (QAPI), F 867-QAPI/Quality Assessment and Assurance (QAA). The IJ began on [DATE] and continued until [DATE] when survey team verified onsite that corrective actions had been implemented. On [DATE] the immediate jeopardy was removed, F 867 was lowered to the severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00047231. Findings Include: Cross-Reference F 578, F 678, F 725, and F 726. The facility's Quality Assurance Performance Improvement Plan with an effective date of [DATE] and last revised on [DATE] and [DATE] documented: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Birmingham Nursing and Rehabilitation Center East		STREET ADDRESS, CITY, STATE, ZIP CODE 733 Mary Vann Lane Birmingham, AL 35215	

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	. How QAPI plan will address key issues .We will identify and prioritize problems and opportunities for improvement along with process improvement plans as needed. Systematically analyze underlying causes of . adverse events. Utilizing Root Cause Analysis and Plan-Do-Study-Act along with Performance Improvement Plans. Performance improvement plans to improve process, systems, outcomes, and satisfaction as deemed necessary from . observations to test change and outcomes. Framework for QAPI . A charter will be written for all QAPI projects. The ED (Executive Director or Administrator) will facilitate discussion on QAPI activities, current projects and outcomes to the governing body and input solicited.Performance Improvement Projects (PIPS) . Our organization will conduct performance improvement projects which take a systemic approach to revise and improve care or services is areas that are identified as needing attention . We will monitor success by noting increased efficiency, improved staff and resident outcomes . How and When PIPS will be developed A charter for each performance improvement project will be clearly established at the beginning of the assigned project which will state goals, scope, timing, barriers, team roles and responsibilities . How the designated team will conduct the PIP . Measurement tools will be selected or created to prove success and . results submitted to QAPI to make policy or systemic changes as needed . The problem solving model the facility will use is PDSA (Plan-Do-Study-Act) in most cases and using Root Cause Analysis to ensure that the root cause and contributory factors are correctly identified . Systematic Analysis and Systemic Action In order to get at the underlying causes of issues . identify root cause and contributing factors by brainstorming interdisciplinary meeting and then documenting the results using flow-chart models . A review of a facility policy titled Quality Improvement Program with a revised date of [DATE] documented: POLICY: The Quality Improvement Committee will assess and monitor the quality of services provided to the residents in the facility in order to identify potential problems and/or opportunities for improvement. The committee will implement and systemically evaluate programs and processes to identified problems in order to proactively improve health care delivery. OBJECTIVE: 1. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Identify how Quality Assurance and Improvement activities will be incorporated . 2. Create systems to provide care and achieve compliance 3. Strive to achieve improvement in specific benchmarks . 4. Utilize data obtained . to identify quality problems, opportunities for improvement, and set priorities for action. 5. Performance Improvement . fix causes of persistent/systematic problems. 6. Performance Improvement Projects . focus on particular problem in one area of the facility or facility wide . 7. Perform root cause analysis, . to improve the process. PROCEDURE: . 4. Review results of . identify action items for any areas needing improvement. 5. Utilize the Monthly Facility QA&A Minutes template. 6. Discuss concerns identified . 7. Identify Quality Improvement opportunities. 8. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide training and education . 9. To perform root cause analysis . 10. Develop a Work Plan . 11. Discuss and/or provide minutes to the Governing Body. The facility's timeline of the incident documented that on [DATE] at 8:00 PM, Licensed Practical Nurse (LPN) #7 was in her car. Around 8:15 PM Certified Nursing Assistant (CNA) #8 entered RI #159's room and noted his/her breathing was shallow and his/her color had changed. At 8:20 PM CNA #8 exited the room hollering for help and Registered Nurse (RN) #9 and the CPR Instructor (INST)/Staffing Coordinator responded. RN #9 observed that RI #159 was in distress and began chest compression. The INST called the Code Blue. LPN #7 returned inside the facility. There were five individual assisting in the code, RN #12, RN #9, LPN #7, LPN #11 and the INST. At 9:16 PM RI #159 expired. Documentation from the QAPI committee meeting on [DATE] was reviewed and included: A facility document titled Monthly Q & A Facility QA & A Minutes dated [DATE]. The document included a section titled Review of Minutes from Last Month . Review of last month/quarter minutes & list any action items to carry forward. This section included a handwritten notation that .reportables were discussed related to nursing CPR incident . The [DATE] QAPI documentation included a form titled 5 Whys Root Cause Analysis Template dated [DATE]. The form documented the problem was .CPR performed on resident that was DNR . Why did this occur? staff started code . Is this the root cause? Yes (circled) . Why did this occur? nurses came from other units to assist . Is this the root cause? Yes (circled) . Why did this occur? Did not verify code status . Is this the root cause? Yes (circled) . Why did this occur? Primary nurse not in the facility . Is this the root cause? Yes (circled) . The [DATE] QAPI documentation did not include a performance improvement plan or PIP, any plan, or describe any corrective actions or monitoring to address the incident that occurred on [DATE]. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted on [DATE] at 9:22 AM with LPN #11. When asked what was RI #159's code status, LPN #11 said, when he entered RI #159's room, he saw nurse performing CPR and assumed code status had been checked. LPN #11 said he performed CPR on RI #159. An interview on [DATE] at 8:55 AM with the LPN #11 said his CPR certification expired on [DATE]. On [DATE] at 11:08 AM during an interview with the Director of Nursing (DON), she said RI #159 was a Do Not Resuscitate, code status. She was asked was the facility policy on CPR/Advance Directives followed on RI #159. She said, no it was not, RI #159 was coded and should not have been. When asked what the concern was with performing CPR on a resident whose Advance Directive specified Do Not Resuscitate, the DON said, it was an error, and it should not have been done, and staff must always follow physician's orders. An interview was conducted on [DATE] at 12:17 PM with the Administrator who said that she oversees the day-to-day operations of the facility and compliance with state and federal regulation. When asked if the incident on [DATE] was taken to QAPI, she stated, she would check. She further reported that an internal investigation was done but it was not reported to the State Agency. On [DATE] at 12:17 PM an interview was conducted with the Administrator. The ADM said she was responsible for the QAPI Program. The ADM said when an adverse event occurred the QAPI team identified the adverse event and worked through the opportunity though the fishbone process. Then, from the identified root cause they developed a performance improvement plan or PIP. The ADM said the incident was discussed on [DATE]. The ADM said the root cause was determined to be the staff nurses did not verify the resident's code status prior to performing CPR. The ADM said none of the nurses were reprimanded for not verifying RI #159's code status. During an interview on [DATE] at 8:20 PM with the Administrator she said the QAPI committee met on [DATE] and reviewed the incident that occurred on [DATE]. The ADM was asked, based on the QAPI review, did the committee identify any changes or recommend any actions. The ADM said the QAPI committee identified the nurse did not follow their policy and process for initiating advance directives and verifying code status. The ADM said the system was not broken. The ADM said the nurse failed to follow their policies. The ADM said the QAPI committee determined that LPN #7 needed to be reported to the Board of Nursing. An interview was conducted on [DATE] at 7:30 PM with the Administrator who said that the QAPI Committee was not aware until [DATE] that a staff member had performed CPR with expired CPR certification was expired. The ADM said the QAPI committee identified a concern that LPN #7 had left the facility to sit in her car without alerting another nurse. When asked what action was taken because of the QAPI meeting, she said a complete investigation was conducted and disciplinary action was taken against the nurse, LPN #7. Regarding the initiation of CPR for staff encountering a resident had an Advanced Directive for DNR status in his/her medical record, she stated the staff were re-trained and re-educated on identifying the code status of the resident, resident rights, CPR, Advance Directives, and DNR status. On [DATE] at 12:39 PM, a follow-up interview was conducted with the Administrator. The ADM said she did not recall reporting the incident to the Governing Body. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted on [DATE] at 10:36 AM with the Regional [NAME] President (RVP) who identified her role as the Regional [NAME] President of the facility's management company also indicated Governing Body was part of the agreement. The RVP said she was made aware on [DATE] that CPR had been provided to a resident with an Advance Directive for DNR on [DATE]. The RVP said the ADM should have notified her of the incident. When asked was she was made aware that one nurse involved in the code with RI #159's, CPR certification was expired. She said, they made me aware on [DATE] that his CPR license had been expired for about 3 months. The RVP said the concern of her not being notified of the adverse event on [DATE] was that she needed to be notified of a system failure so it could be changed or updated so that event never happened again. She further said, the facility needed to honor residents end-of-life wishes. She said the facility did not honor RI #159's end-of-life wishes, staff should not have initiated CPR. When asked should this incident been reported to the State Agency, said, yes, it was an adverse event. ** On [DATE] at 8:54 AM, the facility submitted an acceptable Removal Plan for F 867 which documented: 1. Clinical operations (Clin-Ops) nurse will in-service the Executive Director (ED), Director of Nursing (DNS) and Quality Assurance and Performance Improvement (QAPI) committee on new policy A.3a. titled, Accident/Incident & Adverse Events. 2. ED and DNS will in-service 100% of licensed staff on Accident/Incident & Adverse Event Documentation and Investigation. No licensed staff member will be allowed to work as of 11:59 PM [DATE] until completion of in-service. System to be followed per policy, Notification and Documentation in the Resident's Medical Record: a. The Licensed Nurse shall place the resident on the 24-Hour Report, document the incident, and notify the supervisor and Director of Nursing for follow through prior to the end of shift in which the accident/incident or adverse event occurs. b. The Licensed Nurse may complete a Nurses' Note and update the Resident Care Plan. c. The Nurse's Notes could contain the following documentation . d. (continued on next page)

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