DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS-DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere Rehabilitation And Healthcare Center **DATE SURVEY COMPLETED: April 25, 2022**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	**The State Report incorporates by reference and also cites the findings specified** in the **Federal Report.** An unannounced Complaint and Extended Survey was conducted at this facility from April 13, 2022 to April 25, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was ninety-eight (98). The survey sample size was five (5) residents.		
3201.1.0	**Regulations for Skilled and Intermediate care Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applfcable code requirements of the State Fire Prevention commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following:		
16Del. Code, 1162 Nursin_g_	Cross Refer to the CMS 2567-L survey completed April 25, 2022: F609, F678 and F726.	Cross Reference CMS 2567-L survey F609, F678, and F726.	

Provider's Signature Eileen Mallo Title ADMINISTRATOR Date 5/12/2022

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Staffing:	(c) By January 1, 2002, the minimum staffing level for nursing seNIces direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. **Nursing staff must be distributed In order to meet the following minimum weekly shift ratios:** RN/LPN CNA* Day 1 nurse per 15 res. 1 aide per 8 res. Evening 1:23 1:10 Night 1:40 1:20 * or RN, LPN, or NAtT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on April 25, 2022. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it	1. The facility does not have the ability to retroactively address the unmet PPD requirements for 4/3/2022, 4/4/2022, and 4/9/2022. 2. The facility has determined that all residents have the potential to be affected by failing to provide staffing levels of at least 3.28. The Director of Nursing and Administrator reviewed the staffing patterns for the past 7 days and minimum staffing patterns were met. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that further education was required to the Supervisors in addressing and replacing staff call offs. The Staff Developer/designee will provide in-service education program for the Nursing Supervisors on how to calculate PPD's to ensure staffing patterns are met at a minimum of 3.28. 4. The Director of Nursing/designee will complete a daily review of the staffing patterns to ensure the minimum staffing PPD of 3.28 is met (Attachment 1) x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	5/16/2022

Provider's Signature Ellen Mally Title ADMINISTRATOR D.ate 5/12/2022

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	was determined that for three days out of seven days reviewed, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following, but was not limited to: **4/3/2022 PP0 = 2.69** **4/4/2022 PP0 = 3.15** **4/9/2022 PPD** = 3.09 The facility failed to maintain the minimum PPD staffing requirement of 3.28.		

Provider's Signature [signature] Title ADMINISTRATOR Date 5/12/2022

Kentmere Rehabilitation & HealthCare Center

Week/Month:_____

Date	PPD Met Y or N	Corrective Actions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING _____ B. WING _____	C 04/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint and extended survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection on April 13, 2022 through April 25, 2022. The deficiencies contained in this report are based on interviews, reviews of clinical records and other documentation as indicated. The facility census on the first day of the survey was ninety-eight (98). The survey sample totaled five (5) residents. Abbreviations and Definitions used in this report are as follows: & - and; x - times; Abatement - to end or remove; ADON - Assistant Director of Nursing; Automatic External Defibrillator (AED) - medical device that can analyze the heart's rhythm and, if necessary, deliver an electrical shock, or defibrillation, to help the heart re-establish an effective rhythm; Cardiac Arrest - the stoppage of the heart; Carotid pulse - to check the pulse over the carotid artery by placing your index and middle fingers on your neck to the side of your windpipe; CNA - Certified Nurse's Assistant; Code Blue - It is a call for medical personnel and equipment to attempt to resuscitate a patient especially when in cardiac arrest or respiratory distress or failure; Code Status - refers to the level of medical interventions a patient wishes to have started if their heart or breathing stops; CPR (Cardiopulmonary Resuscitation) - an emergency procedure that is done when	F 000		

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

Electronically Signed | 05/12/2022

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F 000	Continued From page 1 someone's breathing or heartbeat has stopped in hopes of providing time for first responders to arrive; DON - Director of Nursing; Full Code - a designation that means to intercede if a patient's heart stops beating or if the patient stops breathing; IC/SD - Infection Control/Staff Development; Immediate Jeopardy - A situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death and the immediate need for it to be corrected to avoid further or future serious harm; LPN - Licensed Practical Nurse; MAR - Medication Administration Record; MD - Medical Doctor; Neglect - the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary top avoid physical harm, pain, mental anguish or emotional distress; Nonsensically - making no sense; NHA - Nursing Home Administrator; QA - Quality Assurance; RN - Registered Nurse; Sternal rub - technique used to obtain a pain response if a patient appears to be unresponsive and does not awaken to sound or shaking; Straight cath - hollow tube inserted into bladder to obtain urine; TAR - Treatment Administration Record.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		6/3/22

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F 609	Continued From page 2 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and other documentation as indicated, it was determined that for one (R1) out of five residents reviewed for death, the facility failed to ensure an alleged violation of neglect was reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency. On 4/3/22 at 11 PM, R1 was found unresponsive and nursing staff failed to perform CPR on a resident who was a Full Code. R1 expired. During a phone call at 11:15 PM on 4/3/22, E5 (RN) told E8 (Physician/Medical	F 609	1. The facility does not have the ability to retroactively address the unmet reporting requirements for R1. 2. The facility has determined that all residents have the potential to be affected by failing to report allegations of neglect. The Assistant Director of Nursing reviewed the 24-hour resident condition report to ensure that no other resident experienced any occurrence requiring State reporting.	

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F 609	Continued From page 3 Director) that she did not perform CPR on R1. The facility failed to report the incident to the State Survey Agency until 4/5/22 at 4:59 PM, approximately 42 hours later. Findings include: Cross refer to F678 Review of R1's clinical record revealed: 3/30/22 - R1 had a physician's order by E8 (Physician/Medical Director) for CPR. 4/3/22 at 11 PM - R1 was found unresponsive and Nursing personnel failed to check R1's code status, failed to call a Code Blue, failed to initiate CPR and failed to activate the Emergency Response System (EMS) by calling 911. R1 expired and the RN pronounced R1 as deceased. 4/20/22 at 4:34 PM - During an interview, E8 (Physician/Medical Director) confirmed that she received a phone call from E5 (RN) on 4/5/22 at 11:15 PM regarding the incident involving R1. E8 stated that she asked E5 if R1 was a full code and E5 said yes. E8 then asked if CPR was initiated and E5 replied no. Despite the facility's Physician/Medical Director being made aware on 4/5/22 at 11:15 PM that E5 failed to perform CPR on R1, the facility did not report the incident to the State Survey Agency until 4/5/22 at 4:59 PM. 4/25/22 at 6:05 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E4 (IC/SD).	F 609	3. A root cause analysis was conducted by the interdisciplinary team and it was identified that the medical director was unaware of the policy. The facility reviewed the Abuse Policy and the Staff Developer/designee will provide in-service education program for the medical director addressing policies and procedures, regulations, and facility expectations of staff to assure that all allegations of neglect are reported to the facility administration & State Agency in a timely manner. 4. The Assistant Director of Nursing/designee will complete a daily interview (Attachment 1) with the medical director to assure compliance with reporting of staff, resident, family member, or legal representatives allegations of neglect x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)	F 678		

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F 678	Continued From page 4 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interviews, review of clinical records and facility documentation as indicated, it was determined that for one (R1) out of five residents reviewed for death in the facility, the facility failed to ensure that Nursing personnel provided basic life support (CPR) to a resident who was a Full Code. On 4/3/22 at 11 PM, R1 was found unresponsive in his room and nursing personnel failed to check R1's code status, failed to call a Code Blue, failed to initiate CPR and failed to activate the Emergency Response System (EMS) by calling 911. R1 expired and the RN pronounced R1 as deceased. Due to the facility's corrective measures following the incident, this is being cited as an immediate jeopardy, past non-compliance with an abatement date of 4/6/22, which was verified by interviews and review of facility records. Findings include: Cross refer to F609 and F726 The facility's policy entitled "Code Blue (Cardiac Arrest)", effective January 2016, stated: "... Purpose: To provide cardiopulmonary resuscitation (CPR) for those residents who are designated as a 'Full Code' ... Scope and Responsibility: This policy applies to ALL personnel. Early Cardiopulmonary Resuscitation is an important link in the chain of survival for a victim of sudden cardiac or	F 678	Past noncompliance: no plan of correction required.	

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F 678	Continued From page 5 respiratory arrest. Therefore, every employee is responsible to respond immediately and to summon help loudly. Employees certified in CPR will initiate ... (CPR). CPR will provide oxygenated blood to the brain and other vital organs until the advanced medical treatment team arrives. Procedure: 1. Check the victim for responsiveness ... 2. If the person is unresponsive, call loudly, "I need help in room_____" ... 3. Instruct the first responder to notify the charge nurse and activate the Emergency Response System (EMS), by calling 911, and to obtain the Automatic External Defibrillator (AED) located at the Nurse's Station ... 4. Stay with the victim and begin CPR ... 5. Responsibilities of the charge nurse include: - Bring the 'crash cart' and the AED. - Designate a qualified person to prepare the resident for transfer by notifying the resident's physician, preparing copies of the MAR, TAR, face sheet, most recent physician orders and history & physical ... The nurse will also notify the next of kin/Power of Attorney. - Make appropriate calls to summon additional assistance from other floors. - Designate staff as needed to obtain supplies, etc. - Document all aspects of the Code Blue including initiation, notification of MD, family, EMS, and outcome to the resident, etc. in the electronic record." 3/30/22 - R1 was admitted to the facility status post hospitalization with an admitting diagnosis of achalasia of cardia (rare disorder of the esophagus that makes it difficult to swallow food and drink).	F 678		

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F 678	Continued From page 6 3/30/22 - A physician's order by E8 (Physician) documented R1 as "FULL CARDIOPULMONARY RESUSCITATION (CPR)." 4/3/22 at 11:32 PM - A progress note by E5 (RN) documented, "At approximately 11:00 was called into the room by CNA stating the resident was not responsive. Upon entering the room noted his skin color was gray and ashy, pupils fixed and dilated, chest rise absent. Non-responsive, no carotid pulse, cool to the touch, no breathing for three minutes. Attempted to around (sic) resident via sternal rub. Time of death called at 11:15 PM. Last interaction was at approximately 10:30 PM, patient was anxious about using the urinal and speaking nonsensically. Vital signs taken early in the shift did not show cause for concern. Staff continued to monitor for safety up until the end of shift when CNA called attention to the nurse. Family was notified and is on the way to visit the body. MD was also notified." 4/20/22 at 11:09 AM - During an interview, E5 (RN) confirmed that she did not check R1's code status and did not perform CPR. E5 stated that after she pronounced R1 (at 11:15 PM), she returned to the nurse's station to notify the Physician and R1's family. E5 stated that when she looked at R1's electronic clinical record, she immediately saw that R1 was a full code. E5 stated that she was asked if she performed CPR during the phone call with E8 (Physician). E5 stated she told E8 that she did not perform CPR. 4/20/22 at 12:16 PM - During an interview, E6 (LPN) stated that she was sitting in the nurse's station when E7 (CNA) notified E5 that R1 was unresponsive. E6 stated that she responded to	F 678		

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F 678	Continued From page 7 R1's room behind E5. E6 stated that she was not familiar with R1. E6 confirmed that she did not think about checking R1's code status and did not bring any equipment (Crash Cart/AED) to R1's room. 4/25/22 at 12:55 PM - The facility's documented response to R1's incident included: -E2 (DON) was made aware by the 1st floor Unit Manager that R1 had an order for Full Code status at the time of his death on 4/5/22 at 3 PM. -The facility's IDT (interdisciplinary team) met on 4/5/22 at 3:05 PM to discuss the situation, they determined that this was a reportable incident and began to implement corrective measures. -E2 (DON) met with E5 (RN), the assigned Nurse on duty and Supervisor responsible for the care of R1 at the time of the incident on 4/5/22 at 3:15 PM. Verbal education and discipline were administered. The 3-11 Supervisor was assigned to monitor and evaluate the nurse's performance for two weeks and then a follow up meeting was scheduled. -E6 (LPN) received verbal education on Initiating CPR Policy and Practice by E4 (IC/SD) on 4/5/22. -A full house audit comparing physician orders to Code Status consent forms was completed and no additional issues were identified on 4/5/22 at 8 PM. A comprehensive chart review was also conducted on R1. -Beginning on the 7-3 shift on 4/6/22, E4 (IC/SD) began educating licensed staff on the CPR policy and procedure, regulations, and facility expectations, specifically to verifying residents code status' upon finding them unresponsive. Live Code Blue Drills were also implemented at the time of education. Education continued around the clock through 4/11/22, then continued with staff who were not scheduled to work during	F 678		

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F 678	Continued From page 8 the initial education period. -An interdisciplinary root cause analysis was conducted on 4/7/22 at approximately 10 AM. A QA indicator was developed with an auditing form for ongoing monitoring. The Staff Developer/designee will continue to conduct "Code Blue" drills with licensed nursing staff two times a week for 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly "Code Blue" drills will be conducted for 3 months or until results are 100% for 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. -On the first anticipated orientation class following the incident, scheduled 4/27/22, the Staff Development Nurse will also provide education on CPR policy and procedure, regulations, and facility expectations specifically to verifying residents code status' upon finding them unresponsive at the new hire and annual orientations. 4/25/22 at 6:05 PM - Findings were reviewed during an Exit Conference with E1 (NHA), E2 (DON) and E4 (IC/SD). As a result of the facility's corrective measures in response to the incident, with an abatement date of 4/6/22 that was verified by interviews and review of facility documentation, this deficiency was cited as past non-compliance.	F 678		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 726		6/3/22

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F 726	Continued From page 9 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and review of the clinical record and facility documentation as indicated, it was determined that for one (R1) out of five residents reviewed for death, the facility failed to ensure that licensed nurses had the skill sets necessary to provide care for R1's needs, as per his individualized plan of the care. First, E5 (RN) failed to thoroughly assess R1 when he had a change of condition at 10:30 PM on 4/3/22. Second, E5 (RN) and E6 (LPN) failed to check	F 726	1. The facility does not have the ability to retroactively reassess R1 when a change in condition was identified. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. The Assistant Director of Nursing reviewed the 24-hour resident condition report to ensure that no	

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	085001	A. BUILDING _____ B. WING _____	C 04/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 10 R1's code status as he was a Full Code and failed to implement the facility's policy and procedure for Code Blue, which included CPR, when R1 was found in his room unresponsive at 11 PM on 4/3/22. Findings include: Cross refer to F678 1a. Review of R1's clinical record revealed: 3/30/22 at 9:21 PM - R1's admission evaluation documented that he was alert and oriented x (times) 3 (to person, place and time), some forgetfulness but pleasant, his speech was clear, and he was able to understand and be understood when speaking. In addition, R1 could use the urinal and was continent. 4/1/22 at 7:04 AM - A nurse's note documented that R1 remained alert and oriented x3 and was continent utilizing assistance with the urinal. 4/3/22 at 11:32 PM - A nurse's note written by E5 (RN) documented that her "... Last interaction was at approximately 10:30 PM, patient (R1) was anxious about using the urinal and speaking nonsensically. Vital signs taken early in the shift did not show cause for concern...". R1's last vital signs were taken at 4:36 PM on 4/3/22. 4/20/22 at 11:09 AM - During an interview, E5 (RN) stated that on 4/3/22 at approximately 10:30 PM, R1 was restless, talking, but not making sense and saying there was water on the floor when there was none. E5 stated that she was worried about R1 getting out of bed and kept reassuring him every time she passed his door in the hallway. E5 stated that she left R1 to bladder scan and straight cath two other residents across	F 726	other resident experienced a change in condition that was not thoroughly assessed. No further issues identified. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that the staff member (E5) failed to thoroughly assess R1 after it was identified that he experienced a change in condition. The Director of Nursing provided an education to E5, addressing the thorough assessment of residents who experience a change in condition and assigned the 3-11 RN Supervisor to provide close supervision to E5's performance, including assessment and documentation. The Staff Developer/Designee will educate all licensed nursing staff on thorough assessments when a resident experiences a change in condition. 4. The Director of Nursing/designee met with the 3-11 RN Supervisor daily x 2 weeks to discuss E5's competency level to determine if any additional action is needed. At the completion of the 2-week monitoring Period, the facility determined that E5's did not adequately meet the facility expectations and was terminated from employment. The Quality Assurance Nurse/designee will complete a daily review of the 24-hour resident condition report to identify ant resident who experienced a change in condition (Attachment 2). Those residents will be reviewed to ensure a thorough nursing assessment was	

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F 726	Continued From page 11 the hall from R1's room before the end of her shift with the assistance of the other floor nurse, E6 (LPN). R1's clinical record lacked evidence that E5 thoroughly assessed R1, including vital signs, despite a change of condition before leaving him to provide care to two other residents. 1b. Review of R1's clinical record and facility documentation revealed: 4/3/22 at 11 PM - According to the facility's incident report and statements, E7 (CNA) notified E5 (RN) that R1 was unresponsive in his room. E6 (LPN) stated that she responded to R1's room after E5. Despite R1 having an active physician's order for CPR, R1 was found without signs of life and was pronounced as deceased by E5 (RN) at 11:15 PM. 4/20/22 at 11:09 AM - During an interview, E5 (RN) stated that she had just sat down in the nurse's station when E7 (CNA) notified her that R1 was unresponsive. E5 confirmed that she did not check R1's code status and did not perform CPR, even after learning R1's code status. 4/20/22 at 12:16 PM - During an interview, E6 (LPN) stated that she was sitting at the nurse's station when E5 (RN) was notified by E7 (CNA) that R1 was unresponsive. E6 stated that she was not familiar with R1. E6 confirmed that she did not think about checking R1's code status and she did not bring any equipment (Crash Cart/AED) to R1's room. 4/25/22 at 6:05 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2	F 726	completed. x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 1. The facility does not have the ability to retroactively Determine R1 code status and respond appropriately. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. The facility CPR policy was reviewed; no changes necessary. A full house audit comparing physician order to Code Status consent forms was completed and no additional issues were identified. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that further education was necessary. The Staff Developer/ Designee has provided education to all licensed nursing staff regarding CPR policy and procedure, regulations, and facility expectations, specifically in verifying residents code status upon finding them unresponsive, Live Code	

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F 726	Continued From page 12 (DON) and E4 (IC/SD). The facility failed to ensure that licensed nurses on duty had the skill sets necessary to provide care when R1 had a change of condition at 10:30 PM followed by an unresponsive incident at 11 PM.	F 726	Blue drills were also conducted in conjunction with the education for all nurses. 4. The Staff Developer/designee will continue to conduct Code Blue Drills (Attachment 3) with licensed nursing staff twice a week x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	