

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2024
NAME OF PROVIDER OR SUPPLIER LEGACY MANOR NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704		
(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 The State Agency (SA) conducted a Complaint Investigation (CI) MS #25982, CI MS #26389 and CI MS #26398 at the facility on 9/9/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid for CI MS #26389 and CI MS #26398. The facility failed to provide Cardiopulmonary Resuscitation (CPR) and emergency services to a resident who was found to have no respirations and no pulse. There were no deficiencies cited for CI MS #25982 related to physician appointments. On 9/4/24 at 7:45 PM, Resident #1, who had a Full Code status, was found without respirations or a pulse. The nurse did not initiate CPR or activate emergency services for Resident #1. The facility's failure to provide CPR and implement the care plan resulted in Resident #1 not receiving life sustaining measures and he expired at the facility. During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 9/9/24. IJ and SQC existed at: 42 CFR(s): 483.24 (a)(3) - Cardiopulmonary Resuscitation (F678) Scope and Severity "J". IJ existed at: 42 CFR(s): 483.21(b)(1)(i) - Comprehensive Care Plans (F656) Scope and Severity "J". The SA notified the facility's Administrator of the IJs and SQC on 9/9/24 at 3:02 PM and provided	F 000	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/12/2024

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

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F 000	Continued From page 1 the Administrator with the IJ templates. Based on the facility's implementation of corrective actions on 9/5/24, the SA determined the IJs and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 9/6/24, prior to the SA's first entrance on 9/9/24. At the time of the survey, the facility was licensed for 60 beds and had a census of 49.	F 000			
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656			

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F 656	Continued From page 2 rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review the facility failed to implement care plan interventions related to Cardiopulmonary Resuscitation (CPR) for a resident who was found to have no respirations and no pulse for one (1) of three (3) sampled residents. Resident #1. The facility's failure to implement the care plan for Resident #1 resulted in the resident not receiving CPR and emergency services when he was found without pulse, respirations or blood pressure. Resident #1 was a Full Code status. The resident subsequently expired in the facility. The situation was determined to be an Immediate Jeopardy (IJ) that began on 9/4/24 when Resident #1 was found by facility staff to be	F 656	Past noncompliance: no plan of correction required.		

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F 656	Continued From page 3 unresponsive and without respirations, a pulse or blood pressure. The facility Administrator was notified of the IJ on 9/9/24 at 3:02 PM and was provided an IJ Template. Based on the facility's implementation of corrective actions on 9/5/24 the State Agency (SA) determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed as of 9/6/24, prior to the SA's first entrance on 9/9/24. Findings Include: Review of the facility's "Care Plan Process" policy, latest revision date 08/17, revealed "... Interventions are actions that should promote meeting the established goal..." Record review of Resident #1's care plan dated 3/3/24, revealed " Advanced Directive - Full Code. Goal: Honor Residents wishes...Approaches: ...Honor Resident/Family Advance Directive request...Full Code." A review of the "Progress Notes" by Licensed Practical Nurse #1 (LPN) dated 9/4/24 at 7:45 PM, revealed that she walked by Resident #1's room and noticed he did not look well. Upon entering the room, she found the resident unresponsive, with no respirations, pulse, or blood pressure. She then notified the coroner, the family, the Administrator, and the Nurse Practitioner of the resident's death. There was no indication that CPR was initiated or that emergency services were called.	F 656			

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F 656	Continued From page 4 Record review of "Resident/Family Consent for Cardiopulmonary Resuscitation (CPR)" for Resident #1, dated 3/3/20, revealed "I understand that CPR constitutes an extraordinary measure and SHOULD be done on this resident in the case of extreme emergency." Record review of Resident #1's "Physician's Telephone Order" dated 3/3/20 revealed an order for "Full Code" indicating that the resident should receive CPR. On 9/9/24 at 1:30 PM, during an interview the Administrator confirmed that the care plan was not followed, and Resident #1 did not receive CPR. Record review of the "Facesheet" for Resident #1 revealed the facility admitted Resident #1 on 3/3/20 with diagnoses that included Dementia and Chronic Kidney Disease. The facility submitted the following acceptable Corrective Action Plan on 9/9/24: Corrective Action Plan On September 4, 2024, while making rounds at 7:45 PM, Licensed Practical Nurse #1 reports glancing into Resident #1's room and observed resident not looking right and entered Resident #1's room to assess Resident #1's status. Licensed Practical Nurse #1 reports that resident was without active vital signs, face and upper arms cool to touch, rest of body warm. Licensed Practical Nurse #1 then placed a call to the coroner at 7:55 PM and did not initiate cardiac resuscitation measures and call 911. Resident #1 medical record indicates resident was with full	F 656			

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F 656	Continued From page 5 code status. Licensed Practical Nurse #1 notified facility Administrator of resident death at 8:00 PM. Licensed Practical Nurse #1 notified Staff Development Nurse #1 at 8:05 PM who instructed Licensed Practical Nurse # 1 to initiate Cardiopulmonary Resuscitation efforts. Licensed Practical Nurse #1 notified Nurse Practitioner at 8:10 PM of resident death. Licensed Practical Nurse #1 contacted Resident #1's sister at 8:15 PM and resident's family arrived at the facility at 8:45 PM. On September 5, 2024, approximately 8:20 AM, it was determined by Staff Development Nurse #1 that Licensed Practical Nurse #1 did not initiate Cardiopulmonary Resuscitation efforts. On September 5, 2024, at approximately 8:30 AM the facility Administrator was notified by Assessment Nurse #1 of the failure by Licensed Practical Nurse #1 to initiate cardiopulmonary resuscitation on Resident #1. On September 5, 2024, at approximately 9:35 AM, Licensed Practical Nurse #1 was suspended via telephone by facility Administrator pending investigation. On September 5, 2024, at approximately 9:30 AM, the facility Administrator interviewed Licensed Practical Nurse #1. The interview indicated Licensed Practical Nurse #1 was aware of the full code status and did not initiate Cardiopulmonary Resuscitation due resident being without signs of life. On September 5, 2024, the Regional Supervisor and Vice President interviewed Licensed Practical Nurse #1 via telephone. The interview indicated	F 656			

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F 656	Continued From page 6 the Licensed Practical Nurse #1 did not initiate Cardiopulmonary Resuscitation. On September 5, 2024, the Assessment Nurse #1, interviewed the three Certified Nurse's Aide on shift at the time of the incident. The Certified Nurse Aide #1 was interviewed and confirmed that Cardiopulmonary Resuscitation was not initiated by Licensed Practical Nurse #1. The Certified Nurse Aide #2 was interviewed and reported that she had informed Licensed Practical Nurse #1 to start Cardiopulmonary Resuscitation after speaking to Staff Development Nurse #1 via telephone on the evening of September 4, 2024. Certified Nursing Aide #2 also reported that Licensed Practical Nurse #1 stated "no" because he is already deceased. Certified Nurse Aide #3 was interviewed and reported that Licensed Practical Nurse #1 did not perform Cardiopulmonary Resuscitation on Resident #1. On September 5, 2024, the approximately 4:30 PM, the State Department of Health was notified of the initial report via telephone of the incident. On September 6, 2024, at approximately 2:00 PM, an initial report was submitted to local law enforcement, Attorney General's Office, and the Mississippi Board of Nursing of the incident involving Licensed Practical Nurse #1. On September 6, 2024, at approximately 3:30 PM Licensed Practical Nurse #1 was terminated via telephone for failure to follow instructions from Staff Development Nurse #1 to initiate cardiopulmonary resuscitation on Resident #1 per facility policy.	F 656			

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F 656	Continued From page 7 A facility Quality Assurance Committee meeting was held at approximately 3:30 PM, September 5, 2024, to include facility Quality Assurance Committee members which consisted of the facility Administrator #1, Corporate Nurse #1, Regional Supervisor #1, Staff Development Nurse #1, Infection Preventionist Nurse, Medical Director #1, Assessment Nurse #1, Social Service Director #1, Activities Director #1 and Administrative Assistant #1. Topics discussed included: Failure to initiate CPR measures for a full code resident. The facility corrective actions were reviewed and initiated September 5, 2024, to include the following: in-service training, code drills, medical record audits, and monitoring systems ongoing. On September 5, 2024, in-service training was initiated by Staff Development Nurse #1 and Assessment Nurse #1 to include all Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Housekeeping and Laundry staff, office personnel and contracted therapy department on the following: (a) Cardiopulmonary Resuscitation Policy, (b) Change in Resident Medical Status, (c) Emergency Care of Residents, (d) Care Plan Process, (e) Advance Directives, physician orders (f) Resident Rights, (g) Resident Abuse/Neglect and Reporting. The in-service conducted on September 5, 2024, included two (2) Registered Nurses, five (5) Licensed Practical Nurses, and eight (8) Certified Nursing Assistants. Facility staff and agency staff if utilized will not be allowed to work until the proper in-service training has been conducted. On September 5, 2024, Cardiopulmonary Resuscitation (CPR) Code Drills were initiated by	F 656			

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F 656	Continued From page 8 the facility Staff Development Nurse #1 and the facility Assessment Nurse #1 for all Registered Nurses and Licensed Practical Nurses. Registered Nurses and Licensed Practical Nurses will not be allowed to provide direct patient care until participation in a code drill has been conducted. Code drill exercises will be performed daily until all Registered Nurses and Licensed Practical Nurses have participated in at least one exercise, and then code drills will continue as outlined below. On September 5, 2024, all active resident's medical record charts were audited by the facility Staff Development Nurse #1, and Assessment Nurse #1 to ensure proper code status identification. The results of this audit showed one discrepancy found and was immediately corrected. On September 5, 2024, all active residents plan of care were audited by the facility Assessment Nurse #1 and the Staff Development Nurse #1 to ensure proper code status identification. The audit results showed no issues found. On September 5, 2024, monitoring systems were put in place to sustain compliance. (a) Verify licensed staff Cardiopulmonary Resuscitation certification status upon hire and monthly by the Director of Nursing. (b) All active resident medical records and plan of care will be monitored for the correct code status weekly for four (4) weeks, bi-weekly for three (3) months, then monthly thereafter. (c) the facility began monitoring cardiopulmonary resuscitation code drills on all three shifts, weekly times four (4) weeks, monthly time three (3) months, then per facility protocol thereafter (every four (4) months rotating shifts)	F 656			

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F 656	Continued From page 9 (d) the facility began crash cart inventory checks for 30 days and then weekly thereafter. The facility Administration will have a follow up Quality Assurance Meeting on September 26, 2024, and monthly times two months and then quarterly thereafter. The facility alleges that all corrective actions to remove the IJ were completed on September 5, 2024, and the Immediate Jeopardy was removed as of September 6, 2024. Validation: The State Agency (SA) validation of the Corrective Action Plan was made on-site during the Complaint Investigation (CI) MS #26389 and CI MS #26398. On 9/9/24, the SA validated through record review and interviews that all corrective actions to remove the IJ were completed by the facility on 9/5/24 and the IJ was removed on 9/6/24, prior to the SA entering the building on 9/9/24.	F 656			
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §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, record review, and facility policy review, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) and	F 678	Past noncompliance: no plan of correction required.		

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F 678	Continued From page 10 provide emergency services to a resident who was found to have no respirations and no pulse for one (1) of three (3) sampled residents. Resident #1. Resident #1, who had a Full Code status, was found to have no respirations and no pulse. The nurse did not initiate CPR or activate emergency services for Resident #1. The resident expired in the facility. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/4/24 when Resident #1 was found by facility staff to be unresponsive and without respirations, a pulse or blood pressure. The facility Administrator was notified of the IJ and SQC on 9/9/24 at 3:02 PM and was provided an IJ Template. Based on the facility's implementation of corrective actions on 9/5/24, the State Agency (SA) determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 9/6/24, prior to the SA's first entrance on 9/9/24. Findings Include: A record review of the facility's "Cardiac Resuscitation Policy" latest revision date 02/24, revealed, "It is the policy of this facility to provide basic life support, including CPR, Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician orders and resident choice indicated in the resident's advance directives. Nurses and	F 678			

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F 678	Continued From page 11 other care staff are educated to initiate CPR unless a valid Do Not Resuscitate (DNR) order is in place or obvious clinical signs of death are present such as rigor mortis ..." Record review of the "Progress Notes" by Licensed Practical Nurse (LPN) #1 dated 9/4/24 at 7:45 PM, revealed that she walked by Resident #1's room and noticed he did not look well. Upon entering the room, she found the resident unresponsive, with no respirations, pulse, or blood pressure. She then notified the coroner, the family, the Administrator, and the Nurse Practitioner of the resident's death. There was no indication that CPR was initiated or that emergency services were called. Record review of a Progress Note dated 9/5/24 at 2:57 PM by LPN #1 revealed a clarification note for 9/4/24, "In my previous noted, I did not make it understandable that Resident's face and upper arms were cool to touch but when I uncovered lower arms and legs, his body was still warm ..." Record review of "Resident/Family Consent for Cardiopulmonary Resuscitation (CPR)" for Resident #1, dated 3/3/20, revealed "I understand that CPR constitutes an extraordinary measure and SHOULD be done on this resident in the case of extreme emergency." Record review of Resident #1's "Physician's Telephone Order" dated 3/3/2020 revealed an order for "Full Code" indicating that the resident should receive CPR. An interview with the Staff Development Coordinator on 9/9/24 at 12:45 PM, revealed that she instructed LPN #1 via phone to initiate CPR	F 678			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2024
NAME OF PROVIDER OR SUPPLIER LEGACY MANOR NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704		
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F 678	Continued From page 12 on Resident #1. Staff Development Coordinator further stated that when she asked LPN #1 why she had not performed CPR on Resident #1 LPN #1 responded it was because the resident was already deceased. The Deputy County Coroner revealed in an interview on 9/9/24 at 12:59 PM, that she received a call from LPN #1 on 9/4/24 at 7:55 PM, reporting Resident #1's death at 7:45 PM. The Coroner noted that facilities typically notify her after CPR and emergency services have been attempted. She pronounced Resident #1 deceased at the facility at 8:22 PM and observed that the resident did not exhibit rigor mortis or dependent lividity. The Deputy County Coroner further reported that when asked why CPR had not been initiated, LPN #1 stated that she had last seen the resident alive at 6:20 PM and was unsure of the exact time of death. During an interview on 9/9/24 at 1:30 PM, the Administrator confirmed that CPR should have been initiated on Resident #1, but it was not performed. Record review of the "Facesheet" for Resident #1 revealed the facility admitted Resident #1 on 3/3/20 with diagnoses that included Dementia and Chronic Kidney Disease. The facility submitted the following acceptable Corrective Action Plan on 9/9/24: Corrective Action Plan On September 4, 2024, while making rounds at 7:45 PM, Licensed Practical Nurse #1 reports glancing into Resident #1's room and observed	F 678			

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F 678	Continued From page 13 resident not looking right and entered Resident #1's room to assess Resident #1's status. Licensed Practical Nurse #1 reports that resident was without active vital signs, face and upper arms cool to touch, rest of body warm. Licensed Practical Nurse #1 then placed a call to the coroner at 7:55 PM and did not initiate cardiac resuscitation measures and call 911. Resident #1 medical record indicates resident was with full code status. Licensed Practical Nurse #1 notified facility Administrator of resident death at 8:00 PM. Licensed Practical Nurse #1 notified Staff Development Nurse #1 at 8:05 PM who instructed Licensed Practical Nurse #1 to initiate Cardiopulmonary Resuscitation efforts. Licensed Practical Nurse #1 notified Nurse Practitioner at 8:10 PM of resident death. Licensed Practical Nurse #1 contacted Resident #1's sister at 8:15 PM and resident's family arrived at the facility at 8:45 PM. On September 5, 2024, approximately 8:20 AM, it was determined by Staff Development Nurse #1 that Licensed Practical Nurse #1 did not initiate Cardiopulmonary Resuscitation efforts. On September 5, 2024, at approximately 8:30 AM the facility Administrator was notified by Assessment Nurse #1 of the failure by Licensed Practical Nurse #1 to initiate cardiopulmonary resuscitation on Resident #1. On September 5, 2024, at approximately 9:35 AM, Licensed Practical Nurse #1 was suspended via telephone by facility Administrator pending investigation. On September 5, 2024, at approximately 9:30 AM, the facility Administrator interviewed	F 678			

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F 678	Continued From page 14 Licensed Practical Nurse #1. The interview indicated Licensed Practical Nurse #1 was aware of the full code status and did not initiate Cardiopulmonary Resuscitation due resident being without signs of life. On September 5, 2024, the Regional Supervisor and Vice President interviewed Licensed Practical Nurse #1 via telephone. The interview indicated the Licensed Practical Nurse #1 did not initiate Cardiopulmonary Resuscitation. On September 5, 2024, the Assessment Nurse #1, interviewed the three Certified Nurse's Aide on shift at the time of the incident. The Certified Nurse Aide #1 was interviewed and confirmed that Cardiopulmonary Resuscitation was not initiated by Licensed Practical Nurse #1. The Certified Nurse Aide #2 was interviewed and reported that she had informed Licensed Practical Nurse #1 to start Cardiopulmonary Resuscitation after speaking to Staff Development Nurse #1 via telephone on the evening of September 4, 2024. Certified Nursing Aide #2 also reported that Licensed Practical Nurse #1 stated "no" because he is already deceased. Certified Nurse Aide #3 was interviewed and reported that Licensed Practical Nurse #1 did not perform Cardiopulmonary Resuscitation on Resident #1. On September 5, 2024, the approximately 4:30 PM, the State Department of Health was notified of the initial report via telephone of the incident. On September 6, 2024, at approximately 2:00 PM, an initial report was submitted to local law enforcement, Attorney General's Office, and the Mississippi Board of Nursing of the incident involving Licensed Practical Nurse #1.	F 678			

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F 678	Continued From page 15 On September 6, 2024, at approximately 3:30 PM Licensed Practical Nurse #1 was terminated via telephone for failure to follow instructions from Staff Development Nurse #1 to initiate cardiopulmonary resuscitation on Resident #1 per facility policy. A facility Quality Assurance Committee meeting was held at approximately 3:30 PM, September 5, 2024, to include facility Quality Assurance Committee members which consisted of the facility Administrator #1, Corporate Nurse #1, Regional Supervisor #1, Staff Development Nurse #1, Infection Preventionist Nurse, Medical Director #1, Assessment Nurse #1, Social Service Director #1, Activities Director #1 and Administrative Assistant #1. Topics discussed included: Failure to initiate CPR measures for a full code resident. The facility corrective actions were reviewed and initiated September 5, 2024, to include the following: in-service training, code drills, medical record audits, and monitoring systems ongoing. On September 5, 2024, in-service training was initiated by Staff Development Nurse #1 and Assessment Nurse #1 to include all Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Housekeeping and Laundry staff, office personnel and contracted therapy department on the following: (a) Cardiopulmonary Resuscitation Policy, (b) Change in Resident Medical Status, (c) Emergency Care of Residents, (d) Care Plan Process, (e) Advance Directives, physician orders (f) Resident Rights, (g) Resident Abuse/Neglect and Reporting. The in-service conducted on September 5, 2024, included two (2) Registered Nurses, five (5)	F 678			

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F 678	Continued From page 16 Licensed Practical Nurses, and eight (8) Certified Nursing Assistants. Facility staff and agency staff if utilized will not be allowed to work until the proper in-service training has been conducted. On September 5, 2024, Cardiopulmonary Resuscitation (CPR) Code Drills were initiated by the facility Staff Development Nurse #1 and the facility Assessment Nurse #1 for all Registered Nurses and Licensed Practical Nurses. Registered Nurses and Licensed Practical Nurses will not be allowed to provide direct patient care until participation in a code drill has been conducted. Code drill exercises will be performed daily until all Registered Nurses and Licensed Practical Nurses have participated in at least one exercise, and then code drills will continue as outlined below. On September 5, 2024, all active resident's medical record charts were audited by the facility Staff Development Nurse #1, and Assessment Nurse #1 to ensure proper code status identification. The results of this audit showed one discrepancy found and was immediately corrected. On September 5, 2024, all active residents plan of care were audited by the facility Assessment Nurse #1 and the Staff Development Nurse #1 to ensure proper code status identification. The audit results showed no issues found. On September 5, 2024, monitoring systems were put in place to sustain compliance. (a) Verify licensed staff Cardiopulmonary Resuscitation certification status upon hire and monthly by the Director of Nursing. (b) All active resident medical records and plan of care will be monitored for the	F 678			

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F 678	Continued From page 17 correct code status weekly for four (4) weeks, bi-weekly for three (3) months, then monthly thereafter. (c) the facility began monitoring cardiopulmonary resuscitation code drills on all three shifts, weekly times four (4) weeks, monthly time three (3) months, then per facility protocol thereafter (every four (4) months rotating shifts) (d) the facility began crash cart inventory checks for 30 days and then weekly thereafter. The facility Administration will have a follow up Quality Assurance Meeting on September 26, 2024, and monthly times two months and then quarterly thereafter. The facility alleges that all corrective actions to remove the IJ were completed on September 5, 2024, and the Immediate Jeopardy was removed as of September 6, 2024. Validation: The State Agency (SA) validation of the Corrective Action Plan was conducted on-site during the Complaint Investigation (CI) MS #26389 and CI MS #26398. On 9/9/24, the SA validated through record review and interviews that all corrective actions to remove the IJ were completed by the facility on 9/5/24 and the IJ was removed on 9/6/24, prior to the SA entering the building on 9/9/24.	F 678			