STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

(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 A complaint investigation was conducted from 6/22/2020 through 6/24/2020. Event ID# UQIO11. Two of the six complaint allegations were substantiated resulting in deficiencies .	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		7/21/20

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

Electronically Signed | 07/16/2020

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 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, responsible party, and medical director the facility failed to notify the resident's responsible party (RP) of a resident's death (Resident #1) for 1 of 3 residents reviewed for notification. Findings included: Resident #1 was admitted to the facility on 2/25/2020 with most recent reentry 5/13/2020. His diagnoses included diabetes mellitus (DM), acute on chronic heart failure, high blood pressure, renal insufficiency, chronic obstructive pulmonary disease, and COVID19. The resident's Profile revealed a family member was listed as emergency contact and responsible party (RP). Nursing progress notes dated 6/1/2020 at12:51	F 580	F580D The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide the quality of life for our residents. IMMEDIATE ACTIONS Resident #1 no longer in the facility. No other actions taken for resident #1 IDENTIFICATION OF OTHERS 100% audit of records for all residents who died in the facility in the last six months was completed on 7/16/2020 by Director of Health Services to identify any other resident who died in the facility and	

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F 580	Continued From page 2 am, revealed Nurse # 3 found Resident #1 unresponsive, began CPR, and called Emergency Medical Services (EMS). The resident was pronounced dead by EMS at 7:15pm on 5/31/2020. Nurse #3 documented the family was call three times with no response and EMS transported body to the local hospital morgue. A phone interview was conducted with Resident #1's RP on 6/22/2020 at 2:42pm. RP stated he was never notified by the facility of Resident #1's death. The RP stated he was notified of the resident's death by the hospital morgue on 6/2/2020 at 9:15am. Resident #1's RP stated when the facility had an outbreak of COVID19, all residents were assigned a liaison who would call family daily to update them on a resident's condition. Resident #1 was assigned to the facility's Human Resource (HR) representative. On 5/27/2020 Resident #1's RP notified the HR representative he would be traveling out of the country with his job and he would be calling her for an update on Resident #1 until his return to the United States. On 5/31/2020 around lunch time Resident #1's RP spoke with the HR representative to receive and update on Resident #1 and to confirm with her the cell phone he mailed to Resident #1 had arrived. The HR representative was not in the facility that day, it was a Sunday, but confirmed with him the cell phone had arrived and she would get it to Resident #1 on Monday morning (6/1/2020). The RP also notified the HR representative he would be on an overnight flight returning to the U. S. on 6/1/2020. On 6/22/2020 at 1:09pm an interview was conducted with Human Resource (HR)	F 580	the family was not notified timely. This audit revealed no other death in the facility in which the responsible party of the deceased was not notified timely. 100% audit of all current residents' clinical documentation within the last 7 days completed by the Director of Health services, infection preventionist, Unit manager #1, unit manager #2 and/or wound care nurse, to determine any identified need for notification of changes was completed in a timely manner. The audit revealed no other incident of missing/delayed notification of changes to both physician and responsible party. This audit was completed on 7/15/2020. Findings of this audit is documented on the clinical records audit tool located in the facility compliance binder. 100% audit of all incident reports created within the last 14 days was completed by Director of Health services, infection preventionist, Unit manager #1, unit manager #2 and/or wound care nurse, to ensure notifications resident physician and responsible party were done in a timely manner. The audit revealed no other incident of missing/delayed notification of changes to both physician and responsible party. This audit was completed on 7/16/2020. Findings of this audit is documented on the incident reports audit tool located in the facility compliance binder. SYSTEMIC CHANGES Effective 07/21/2020, the facilities nursing administrative team, which includes Director of Health services, infection preventionist, Unit manager #1, unit	

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F 580	Continued From page 3 representative who was assigned to communicate with Resident #1's RPs during the COVID outbreak. She stated Resident #1 was on her list of residents to contact RPs daily with updates. She stated she spoke with resident's RP frequently up until 5/27/2020 when he told her he would be traveling out of the country with his job. He told her he would be contacting the facility until his return. She stated on 5/31/2020 around 12:56pm she received a call from the RP to confirm she had received the cell phone he mailed to Resident #1 and let her know he had a flight overnight returning home on 6/1/2020. She confirmed she had received the phone and would give it to Resident #1 when she returned to the facility on the morning of 6/1/2020. When she went into the facility on 6/1/2020 nursing staff informed her of the resident's death. She stated she did not attempt to notify the RP on 6/1/2020 or 6/2/2020. An interview was conducted 6/23/2020 at 4:30pm with Nurse #3. Nurse #3 stated she worked night shift on 5/31/2020 and arrived at the facility that evening around the time Resident #1 was found unresponsive. She stated she went into the room and was asked to contact the resident's RP. She further stated she called the first RP listed and left a message. She thought she attempted the second contact number but did not get an answer. She recalled trying the RP number two more times while EMS was in the building but did not get a response from the RP. The Director of Nursing (DON)was made aware of the resident's death and that the nurse was unable to contact the RP on the evening of 5/31/2020. Nurse #3 stated she did not speak to any of Resident #1's family after the death of the resident on 5/31/2020.	F 580	manager #2 and/or wound care nurse, initiated a process for reviewing clinical documentation for the last 24 hours, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, unit manager #1, unit manager #2 and/or Registered Nurse supervisor. This process will be incorporated in daily clinical meeting. Any negative findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 07/21/2020, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place every Saturday & Sunday. Any identified issues will be addressed promptly, and appropriate actions will be implemented by the Registered Nurse supervisor or designated licensed nurse. Any negative findings will be documented on the weekend supervisor form and maintained in the daily clinical meeting binder.	

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F 580	Continued From page 4 On 6/22/2020 at 10:19am an interview was conducted with the Director of Nursing (DON) in which she stated she was on call the night of 5/31/2020 and was made aware of the resident's death by the night shift nurse. She stated she did not attempt to contact the RP that evening but made the ADON aware on the morning of 6/1/2020. At that point the Assistant Director of Nursing (ADON) was given the task of notifying the resident's family. When asked about the facility's protocol if an RP can not be contacted, she stated the facility would send a certified letter to the RP if they could not be reached by phone. The DON stated a certified letter had not been sent to Resident #1's RP. When asked for documentation of attempts to notify family on 6/1/2020 or 6/2/2020 of Resident #1's death, no documentation was provided. An interview was conducted with the ADON on 6/24/2020 at 11:48am. The ADON stated she was made aware of the resident's death on 6/1/2020. She stated she attempted to call the RP around lunch time on 6/1/2020 but did not get an answer. When asked if she documented her attempt to call the RP, she stated she did not. She worked late the evening of 6/1/2020 and when she returned to work on 6/2/2020 the RP had already been notified by the morgue of Resident #1's death. An interview was conducted with the Administrator on 6/22/2020 at 12:33pm. He stated the facility had attempted to notify the RP on 5/31/2020 and left him a message to call the facility. He further stated the call log on 5/27/2020 indicated the RP was out of the country and would call the facility for updates. It was	F 580	Director of Health services (DON), Assistant Director of Health services (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and Medication aides, to include full time, part time and as needed staff. The emphasis of this education will be the importance of notifying Physician and the responsible party in a timely manner for any incident/accidents, residents change of condition, change of treatment/intervention, an injury of unknown source and/or death that occurred in the facility. This education will be completed by 7/21/2020. Any Licensed Nurse or Medication Aide not educated by 7/21/2020, will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and Medication Aides effective 7/21/2020. MONITORING PROCESS Effective 7/21/2020, Director of Health services, and/or Assistant Director of Health services, will monitor compliance with notification of changes to Physician and/or responsible party by reviewing the daily clinical meeting reports to ensure completion, timely notification to Physician and responsible party for any item identified to meet notification requirements. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted by the Director of Health services or Assistant Director of Health services daily Monday to Friday for two weeks, weekly for two more weeks, then	

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F 580	Continued From page 5 unfortunate that the morgue notified the RP before the facility could contact him. When asked about expectations on documentation of attempts to notify family of change in status or death, the Administrator stated it is his expectation that staff document attempts to notify RPs of changes in status or death.	F 580	monthly for three months or until a pattern of compliance is maintained. Effective 7/21/2020, Director of Health services will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Title of person responsible for implementing the acceptable plan of correction: Effective 7/21/20, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of acceptable plan of correction to ensure regulatory compliance. Compliance date: 07/21/2020	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete skin assessments weekly per facility protocol on 1 of 3 (Resident #1) reviewed for pressure sore.	F 658	F658 The creation and submission of this plan of correction does not constitute an admission by this provider of any	7/21/20

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F 658	Continued From page 6 Findings included: Resident #1 was admitted to the facility on 2/25/2020 with most recent reentry 5/13/2020. His diagnoses included diabetes mellitus (DM), acute on chronic heart failure (CHF), high blood pressure, renal insufficiency, chronic obstructive pulmonary disease (COPD), and COVID19 . The resident ' s most recent reentry minimum data set (MDS) dated 5/20/2020 revealed the resident had functional hearing, functional vision, and was able to understand others and was understood by others. The resident was coded as having mildly impaired cognition and no behaviors or moods. He was coded as an everyday smoker. Functionally, the resident was totally dependent upon staff for activities of daily living and personal hygiene. Resident #1 ' s comprehensive care plan dated 3/5/2020 revealed a goal of remaining free of further skin breakdown through next review. The interventions included full skin evaluations with bath/shower as per facility protocol. A record review revealed the last full skin assessment completed on Resident #1 prior to his hospitalization, on 5/5/2020, was completed on 4/11/2020. There were no full skin assessments documented on the resident between 4/11/2020 and 5/5/2020. An interview was conducted with nurse aide (NA) #1 on 6/22/2020 at 12:25pm. NA#1 stated she had been employed in the facility for a few years. She further stated the nurse aides are responsible for documenting and reporting any	F 658	conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide the quality of life for our residents. IMMEDIATE ACTIONS Resident #1 no longer in the facility. No other actions taken for resident #1 IDENTIFICATION OF OTHERS 100% audit of all current residents' records completed by the Director of Health services, Quality Infection preventionist, and/or unit manager #1 and #2 to determine any other resident has a missed skin assessment completed weekly for the last 30 days. This audit was completed on 7/16/2020. Director of Health services, infection preventionist, and/or Nurse Supervisor #1 and #2 completed the skin assessments for all identified residents with missing skin check in 7/16/2020. Findings of this audit are documented on skin assessment audit tool located in the facility compliance binder. SYSTEMIC CHANGES Effective 7/21/2020 the facility licensed nurses on duty will be responsible to complete skin check for active residents weekly following the skin assessment schedule. On 7/15/2020, the facility executive director revised the facility skin assessment schedule to reflect the day of the week each bed in the facility is scheduled for skin check. This schedule will be implemented moving forward effective 7/21/20. Skin assessments will	

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F 658	Continued From page 7 skin breakdown observed during bed baths to the nurse working the hall where the resident resides. NA#1 stated she had worked with the resident prior to his hospitalization for COVID19 on 5/5/2020 but she did not recall if he had any skin breakdown at that time. On 6/22/2019 and interview was conducted with the Director of Nursing. She stated the facility protocol included weekly full skin assessments for each resident and they were routinely completed by the NAs during a bed bath or shower. She further stated she did not know why skin assessments were not documented in Resident #1 ' s electronic medical record after 4/11/2020 and prior to his admission to the hospital on 5/5/2020. She expected full skin assessments to be completed and documented weekly on all residents.	F 658	be scheduled from Sunday to Thursday of each week to allow proper monitoring on the day after being scheduled. Effective 7/21/2020, the facilities nursing administrative team, which includes Director of Health services, assistant director of Health services, Unit manager #1, unit manager #2 and/or wound care nurse, initiated a process for reviewing skin assessments scheduled on previous day to ensure the skin assessment is completed. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or, Unit manager #1, #2, and/or wound care nurse. This process will be incorporated in the daily clinical meeting. Any negative findings will be documented on the weekly assessment monitoring form and maintained in the standard of care binder. Director of Health services (DON), Assistant Director of Health services (ADON) unit manager #1, Unit manager #2 and/or wound care nurse will complete 100% education for all licensed nurses to include full time, part time and as needed staff. The emphasis of this education will be the importance of completing skin assessment in a timely manner following the skin check schedule revised on 7/15/2020. This education will be completed by 7/21/2020. Any Licensed Nurse or Medication Aide not educated by 7/21/2020, will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses effective	

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F 658	Continued From page 8	F 658	7/21/2020. MONITORING PROCESS Effective 7/21/2020, Director of Health services, and/or Assistant Director of Health services, will monitor compliance with completion of skin assessments weekly by reviewing the daily skin assessment monitoring reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted by the Director of Health services or Assistant Director of Health services daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 7/21/2020, Director of Health services will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Title of person responsible for implementing the acceptable plan of correction: Effective 7/21/20, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of acceptable plan of correction to ensure regulatory compliance.	

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F 658	Continued From page 9	F 658	Compliance date: 07/21/2020	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff and facility administrator, and medical director the facility failed to follow physician's order to check respiratory status and vital signs every four hours for 1 of 3 residents (Resident #1) reviewed for respiratory care. Findings included: Resident #1 was admitted to the facility on 2/25/2020 with most recent reentry 5/13/2020. His diagnoses included diabetes mellitus (DM), acute on congestive heart failure (CHF), high blood pressure, renal insufficiency, chronic obstructive pulmonary disease (COPD), and COVID19. Resident #1's most recent comprehensive care plan dated 3/5/2020 revealed a goal of remaining free of signs and symptoms of shortness of breath related to COPD, history of pneumonia, and CHF. Interventions for this goal included	F 695	F695 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide the quality of life for our residents. IMMEDIATE ACTIONS Resident #1 no longer in the facility. No other actions taken for resident #1 IDENTIFICATION OF OTHERS 100% audit of all current residents' records completed on 7/16/2020 by the Director of Health services, infection preventionist, and/or unit manager #1, unit manager #2 and/or wound care nurse to identify any other current resident with a missed vital sign documentation as ordered by a physician in the last 14 days.	7/21/20

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F 695	Continued From page 10 obtaining oxygen levels as per physician's orders and as symptoms warrant. Additionally, the resident had a goal of remaining free of hypertensive episodes. The interventions for this goal included obtaining blood pressure per physician's order and as symptoms warrant. The resident's most recent reentry minimum data set (MDS) dated 5/20/2020 revealed the resident had functional hearing, functional vision, and was able to understand others and was understood by others. The resident was coded as having mildly impaired cognition and no behaviors or moods. He was coded as an everyday smoker. Functionally, the resident was totally dependent upon staff for activities of daily living and personal hygiene. A record review revealed Resident #1 was discharged from the facility on 5/5/2020 with signs and symptoms consistent with COVID19. The resident had been tested for COVID19 twice by the facility, on 4/17/2020 and 5/1/2020, and found to be negative. Hospital records dated 5/5/2020 through 5/13/2020 revealed the resident was positive for COVID19 and found to have pneumonia related to this respiratory virus. He was discharged back to the facility on 5/13/2020. Resident #1's record revealed he was a full code when he returned to the facility on 5/13/2020. A review of the physician's orders for Resident #1 revealed an order, dated 5/13/2020, for vital signs and respiratory assessment every four hours. This included oxygen saturation, blood pressure, pulse rate, respiratory rate, and temperature.	F 695	Director of Health services, infection preventionist, unit manager #1, unit manager #2 and/or wound care nurse completed and documented vital signs for all identified residents with missing vital signs documentation per order on 7/16/2020. Findings of this audit is documented on vital signs audit tool located in the facility compliance binder. SYSTEMIC CHANGES Effective 7/21/2020 the facility licensed nurses, and/or medication aides on duty will be responsible to obtain and document vital signs ordered by physician for active residents as ordered in each resident clinical record. Effective 7/21/2020 the facility licensed nurses, medication aides, and/or certified nursing aide on duty will be responsible to obtain and document vital signs completed per facility protocol (every shift during COVID 19 pandemic, and weekly afterwards), for active residents. Physician order is not required for completion of such vital signs effective 7/21/2020. On 7/15/2020, the facility executive director revised the facility weekly vital sign schedule to reflect the day of the week each bed in the facility is scheduled for vital signs check. This schedule will be implemented moving forward effective 7/21/20 or after the COVID pandemic is declared over, whichever comes last. Vital signs will be scheduled from Sunday to Thursday of each week to allow proper monitoring on the day after being scheduled. Effective 7/21/2020, the facilities nursing	

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	345213	A. BUILDING _____ B. WING _____	C 06/24/2020

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F 695	Continued From page 11 The Medication Administration Record (MAR) for Resident #1 revealed from 5/13/2020 through 5/31/2020 vital signs and respiratory assessments were not completed every four hours. Between 5/13/2020, the date the order was written, and 5/31/2020, the date of the resident's death, there were only two days, 5/22/2020 and 5/28/2020, that the resident's respiratory status and vital signs were monitored every 4 hours per physician's order. Specifically, on the date of the resident's death, 5/31/2020, there were no vital signs or respiratory assessments completed between 10:38am and approximately 6:30pm when the resident was found to be in respiratory and cardiac arrest. The last documented vital signs on Resident #1 on 5/31/2020 were at 10:38am: oxygen saturation 95%, blood pressure 114/77, pulse rate 78 beats per minute, respiratory rate of 19 breaths per minute and a temperature of 97 degrees Fahrenheit. Nursing progress notes were reviewed for 5/31/2020. The last progress note documented on Resident #1 was documented by Nurse #3 at 6:49am. There were no progress notes documented on Resident #1 between 6:49am and approximately 6:30pm when he was found in respiratory and cardiac arrest. Emergency Medical Service's (EMS) record dated 5/31/2020 revealed they arrived at the facility at 6:42pm on 5/31/2020 to find resident #1 cold, absent of pulse, absent of spontaneous respirations, with pupils fixed and dilated at 4mm. Nursing facility staff were attempting to resuscitate Resident #1. The resident was placed on a cardiac monitor and determined to be in	F 695	administrative team, which includes Director of Health services, infection preventionist, Unit manager #1, unit manager #2 and/or wound care nurse, initiated a process for reviewing vital sign documentation for previous day to ensure the vital signs are completed as schedule. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the Director of Health services, infection preventionist, Unit manager #1, unit manager #2 and/or wound care nurse, this process will be incorporated in the daily clinical meeting. Any negative findings will be documented on the weekly vital signs and skin assessment monitoring form and maintained in the standard of care binder. Effective 07/21/2020, week end Registered Nurse supervisor and/or designated licensed nurse will review vital sign documentation for previous day to ensure the vital signs are completed as scheduled. This systemic process will take place every Saturday & Sunday. Any identified issues will be addressed promptly, and appropriate actions will be implemented by the Registered Nurse supervisor or designated licensed nurse promptly. Any negative findings will be documented on the weekend supervisor form and maintained in the daily clinical meeting binder. Director of Health services, infection preventionist, Unit manager #1, unit manager #2 and/or wound care nurse, will complete 100% education for all licensed	

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F 695	Continued From page 12 asystole (no electrical activity). Due to obvious signs of death, resuscitation efforts were not performed by EMS and Resident #1 was pronounced dead. EMS record indicated the resident's nurse stated she knew he was going to die that day. On 6/22/2020 at 2:08pm an interview was conducted with Nurse # 1 in which she stated she cared for Resident #1 on 5/31/2020 during the 7:00am- 7:00pm shift. She stated the resident was up out of bed and in his wheelchair for breakfast and lunch but had a poor appetite. She stated he just seemed weak and tired. She further stated she check the resident last around 5:00pm and he seemed fine, she did not have any cause to be concerned. When asked if she checked the resident's vital signs and respiratory status at 5:00pm or prior to that time, she could not recall but thought she had. Nurse #1 attempted to find documentation of 5:00pm vital signs and respiratory assessment for Resident #1 but was not successful. The last documentation by Nurse #1 was between 4:30pm and 5:00pm when she documented a blood sugar level of 114. Nurse #1 stated she was still in the facility around 6:30pm when Resident #1 was found in respiratory and cardiac arrest and she was in the room when Emergency Medical Services (EMS) arrived. When asked if she made a comment regarding the resident's death in front of EMS, she stated she thought the resident was going to pass. When asked what assessment this was based on, Nurse #1 stated the resident did not have an abnormal presentation that would have warranted her calling the physician, it was just a feeling she had. An interview was conducted with Nurse # 2 on	F 695	nurses, medication aides, and nursing assistants to include full time, part time and as needed nursing staff. The emphasis of this education will be the importance of obtaining and documenting vital signs for each resident as scheduled. This education will be completed by 7/21/2020. Any Licensed Nurse, Medication Aide and/or nursing aide not educated by 7/21/2020, will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses effective 7/21/2020. MONITORING PROCESS Effective 7/21/2020, Director of Health services, and/or Assistant Director of Health services, will monitor compliance with documentation of vital signs by reviewing the daily vital signs monitoring reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted by the Director of Health services or Assistant Director of Health services daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 7/21/2020, Director of Health services will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan	

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F 695	Continued From page 13 6/22/2020 at 3:32pm in which she revealed she also worked with Resident #1 on the date of his death, 5/31/2020. She recalled seeing the resident at breakfast and at lunch time that day and he had a poor appetite. She recalled he removed his oxygen frequently and needed to be reminded to keep the oxygen on. She stated he didn't voice any pain or appear to be in any distress, but he appeared a little gray. Nurse #2 described Resident #1 as having been weak and tired but conversive during her shift on 5/31/2020. When asked if his presentation warranted calling the physician, she stated the resident did not appear to be in distress or in danger of deteriorating. Nurse #2 stated she did not obtain vitals on Resident #1 during the time she worked him on 5/31/2020. An interview with the facility's medical director was conducted on 6/23/2020 at 9:57am. He stated he had been providing services via telehealth since the COVID19 outbreak. He stated he was familiar with Resident #1 and recently placed the resident on intravenous antibiotics after chest x-ray had confirmed pneumonia. He stated the resident was diagnosed with COVID19 during his most recent hospital stay and had many comorbidities including COPD, CHF, and DM that could have contributed to his death. He further stated that if he wrote an order for respiratory status and vital signs to be evaluated every four hours, he expected nursing staff to assess and document this information every four hours.	F 695	to ensure the facility remains in substantial compliance. Title of person responsible for implementing the acceptable plan of correction: Effective 7/21/20, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of acceptable plan of correction to ensure regulatory compliance. Compliance date: 07/21/2020	