STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 04/09/24 through 04/10/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID R7VZ11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted on 04/09/24 through 04/10/24. Event ID R7VZ11.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		5/6/24

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

Electronically Signed | 04/23/2024

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F 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff, and Nurse Practitioner interviews the facility failed to complete an advance directive when the resident elected Do Not Attempt Resuscitate (DNAR) status with limited scope of treatment for 1 of 8 residents reviewed for advance directives (Resident #11). The findings included: Resident #11 was admitted to the facility on 03/29/24. No Minimum Data Set (MDS) information was available. Review of a physician order dated 03/29/24 read: DNAR with limited scope of treatment. If the patient has no pulse and is not breathing: Do Not Attempt Resuscitation. If patient has pulse and/or is breathing but condition is deteriorating, limited scope of treatment. Do use medical treatment determined by the treatment team to be	F 578	On 4/10/24 a confirmation review was completed on all Residents by the MDS/Charge Nurse and the SNF NP regarding current Code Status, Scope of Treatment documentation, forms, and DNAR Bracelet. The screening revealed that the indicated affected resident had the only DNAR order on the unit at the time of survey. A STOP/MOST form was completed and placed on the affected Resident□s chart, and application of the DNAR bracelet was also confirmed for the affected resident at time of survey. On 4/11/24, an immediate plan was discussed and implemented with the SNF provider, Medical Director, MDS/Charge Nurse, and Nurse Manager to complete a proactive review of each new SNF resident admission for ordered Code Status and Scope of Treatment. In addition to documentation in the electronic health record, for patients with a DNAR, the appropriate STOP/MOST Forms will	

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F 578	Continued From page 2	F 578		

appropriate. These treatments may include vasopressors and other medications, intravenous (IV) fluids medications, cardiac monitoring, and synchronized cardioversion. Do consider use of less invasive airway support such as bilevel positive airway pressure (bipap) or continuous positive airway pressure (cpap). Do minimize suffering with medication and wound care. Do provide oral and body hygiene; keep warm and dry. Do consider palliative care consultation. Do not initiate endotracheal intubation or mechanical ventilation. Do not initiate unsynchronized cardioversion (defibrillation). The order indicated that the patient agreed with the order and the resident had current decision-making capacity.

Review of Resident #11's electronic health record on 04/09/24 revealed no advance directive information (DNAR or Medical Orders for Scope of Treatment (MOST) forms) indicating that Resident #11 had chosen to be a DNAR with limited scope of treatment.

Review of Resident #11's folder at the nursing station on 04/09/24 revealed no advance directive information (DNAR or MOST form) indicating that Resident #11 had chosen to be a DNAR with limited scope of treatment.

An observation of Resident #11 was made on 04/09/24 at 10:37 AM. Resident #11 had just ambulated to his room with the assistance from the physical therapist and was sitting on the side of his bed. Nurse #1 was outside of his door preparing his morning medication. Nurse #1 was observed to prepare Resident #11's medication and then entered his room to scan his white identification bracelet that was on his left wrist. No other wrist band was noted on his right or left

be placed indicating the resident□s choices. This will be maintained on the resident□s paper chart, and a copy scanned into the electronic health record. Upon resident discharge the Forms will be sent with the Resident. Continuing on 4/11/24 and ongoing upon admission to SNF, each Resident is provided with written information and available resources for Advance Directives. On 4/11/24 immediate verbal communication was completed with onsite nursing staff regarding the policy and process of application of the DNAR bracelet for indicated residents and use of the STOP/MOST form. A Staff Education Plan including current policy, DNAR Bracelet, Use and Disposition of STOP/MOST Forms will begin on 4/26/24 and be completed by 5/5 for compliance to begin on 5/6/24. Performance monitoring will be completed on all residents admitted to the SNF to verify identification of Code Status, use of the DNAR Bracelet, and appropriate utilization of indicated STOP/MOST forms on resident paper charts. 100% of SNF resident admissions and charts will be reviewed from 4/22/24 ongoing for 6 months. Random monitoring will occur thereafter on an ongoing basis. The plan of correction regarding Code Status/Advanced Directives will be incorporated into the QAPI Plan on 5/6/2024. Data will be reported at least quarterly at the SNF QAA committee meetings and reported up to the Hospital Wide QAPI Committee. The Staff Education Plan will be included in new

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F 578	Continued From page 3 wrist at this time. MDS Nurse #1 was interviewed on 04/09/24 at 3:04 PM. She stated that the facility had recently switched to a new electronic health record and when they did that, they did away with the resident's hard chart and only used folders. Any advance directive information like a DNAR form or MOST forms would be in the folder at the nursing station. MDS Nurse #1 stated that she was not sure if any of the current residents had a DNAR or MOST from but if they did it would be in the folder at the nurse's station. A follow up interview was conducted with MDS Nurse #1 on 04/10/24 at 10:20 AM. MDS Nurse #1 stated that she had looked yesterday and could not locate any DNAR or MOST from for Resident #11. She stated that the facility utilized both the DNAR and Most forms and usually the Nurse Practitioner (NP) would get them completed "at some point during their stay." She added that if there was a question about a resident's code status or advance directive information, the staff would look at the computer and any resident who had a DNAR would have a purple armband in place. The NP was interviewed on 04/10/24 at 10:59 AM. The NP stated that most of the residents in the facility came from the acute care hospital attached to the facility and when they admitted to the unit, she verified that the resident had a code status in place. The NP explained that she typically consulted the MOST form if the resident came in as a full code, but if the resident came in as a DNAR it was not customary to complete the DNAR or MOST form. She stated she had never been told that they have to complete the DNAR or	F 578	staff orientations.	

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F 578	Continued From page 4 MOST form. She explained that they had different tiers of DNAR and those residents would have a purple wristband in place and the staff would look at the computer to find out the residents code status or advance directive information. An observation of Resident #11 was made on 04/10/24 at 12:45 PM. Resident #11 was sitting on the side of his bed eating lunch. He was observed to have a purple wristband in place. The Nurse Manager was interviewed on 04/10/24 at 1:11 PM. The Nurse Manager stated that code status information was written as an order by the provider. She explained that the facility had different levels of code status and scope of treatment. The electronic health system puts that information on a banner in the system and the staff recognized the protocol. If a resident was transported outside of the facility and they wished to have their DNAR or MOST from go with them then the facility would complete them. The Nurse Manager explained that each scope of treatment was different for each resident and was documented in the physician order. "MOST forms are a portable form used" and are not automatically completed. Finally, the Nurse Manager explained that if the computers were down, they had a down time computer which was kept off site and in the event it was needed a manager would have to obtain the down time computer which housed all the resident information. She added that if a resident was a DNAR they would also have a purple wristband in place.	F 578		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		5/6/24

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F 695	Continued From page 5 § 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 observations, record review and staff and resident interviews, the facility failed to post cautionary and safety signs that indicated the use of oxygen for 1 of 1 resident reviewed for respiratory care (Resident #14). The findings included: Resident #14 was admitted to the facility on 04/04/24 with diagnoses that included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia. A review of Resident #14's admission Minimum Data Set assessment was unable to be completed due to Resident #14's recent admission to the facility. Review of Resident #14's physician orders revealed an order for oxygen delivered via nasal cannula at 5 liters per minute (lpm) continuously. An observation of Resident #14 on 04/09/24 at 11:33 AM revealed he was in his room, sitting in his wheelchair, watching television. Resident #14 was observed with a nasal cannula with oxygen being delivered at 5 lpm. There was no cautionary or safety signs noted in Resident #14's	F 695	On 4/10/24 immediate signage was posted on the SNF Entry Doors with clear visibility by public traffic indicating Oxygen in Use. On 4/11/24 verbal communication regarding the posting of the Oxygen in use sign was completed with onsite SNF staff. Further education regarding the Oxygen in Use signage with all SNF staff will begin on 4/26/24 and be completed by 5/5/24 for compliance to begin on 5/6/24. Weekly monitoring ensuring Oxygen in Use signage placement will be completed from 4/10/24 for 3 months. Random monitoring will be completed thereafter and ongoing. The plan of correction for Oxygen in Use Signage monitoring will be incorporated in QAPI/QAA 2024 quarterly data reporting.	

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F 695	Continued From page 6 room, his door, or anywhere in his environment. An interview with Resident #14 on 04/09/24 at 11:34 AM revealed he received oxygen continuously through his nasal cannula and he believed that it was set at 5 lpm. Another observation of Resident #14 was completed on 04/10/24 at 9:48 AM. Resident #14 was in his bed, resting with his eyes closed. Resident #14 was observed wearing his nasal cannula with oxygen being delivered at 5 lpm. There was no cautionary or safety signs noted in Resident #14's room, his door, or anywhere in his environment. An interview with Nurse #1 on 04/10/24 at 12:50 PM revealed Resident #14 admitted from the hospital receiving oxygen continuously at 5 lpm. She reported the facility did not utilize oxygen signage. She reported the hospital where the facility was located was non-smoking and that she did not feel it was necessary to have cautionary or safety signage posted for residents who utilized oxygen. An interview with Nurse Manager on 04/10/24 at 1:13 PM, she reported the facility did not utilize oxygen cautionary and safety signs since the facility was located in a hospital and the hospital was a non-smoking facility. She reported that the facility would obtain safety and cautionary signs and ensure that they were posted.	F 695		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring.	F 867		5/6/24

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F 867	Continued From page 7	F 867		

A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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F 867	Continued From page 8 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance	F 867		

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F 867	Continued From page 9 improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, and Nurse Practitioner interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification survey conducted on 07/07/21. This failure was for one deficiency that was originally	F 867	F867 - QAPI/QAA Improvement Activities - The plan of correction regarding Code Status/Advanced Directives will be incorporated into the QAPI Plan and QAA reporting beginning on 4/22/24 with the final data reporting plan to be completed by 5/5/24 for compliance to begin by 5/6/2024. Data will be reported at least	

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F 867	Continued From page 10 cited in the area of Resident Rights (F578) that was subsequently recited on the current recertification survey of 04/10/24. The repeat deficiency during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F578: Based on observations, record review, staff, and Nurse Practitioner interviews the facility failed to complete an advance directive when the resident elected Do Not Attempt Resuscitate (DNAR) status with limited scope of treatment (Resident #11) for 1 of 8 residents reviewed for advance directives. During the recertification of 07/07/21 the facility failed to follow a resident's wishes for Do Not Resuscitate (DNR) status as specified in their advance directives when the resident went into cardiac arrest (heart stopped) and the facility began Cardiopulmonary Resuscitation (CPR). The Nurse Manager was interviewed on 04/09/24 at 12:02 PM. The Nurse Manager stated that the facility's Quality Assurance (QA) committee consisted of all the managers on the unit, including both Minimum Data Set (MDS) Nurses, direct care staff, and others and they met quarterly. The Nurse Manager also stated that the facility was also a part of the hospital (the facility is attached to) QA meeting that included the pharmacy consultant and medical director. She explained that the facility had an issue with code status several years ago and they had corrected that and they would look at the advance directive	F 867	quarterly at SNF QAA Committee meetings and reported up to the Hospital Wide QAPI Committee and appropriate organization and system leadership. The monitoring plan for compliance of F578 will be completed by 5/5/24 for compliance to begin on 5/6/24. Monitoring results for continued compliance and needed intervention will be reviewed at each SNF QAA meeting for the next 12 months. Education for the QAA Team Members regarding running an effective QAPI program will begin on 4/26/24 to be completed by 5/5/24 for compliance to begin on 5/6/24.	

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F 867	Continued From page 11 information and make any needed adjustments to the their practice.	F 867		