STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115506	A. BUILDING _____ B. WING _____	**08/04/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - FAIRBURN	**7560 BUTNER ROAD FAIRBURN, GA 30213**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure one resident (R#59) out of a sample of 29 residents received the individualized activity program to address and meet the resident's social needs. Findings include: A review of R #59's Face Sheet, dated 8/2/17 indicated the resident had [DIAGNOSES REDACTED]. A review of R#59's care plan, dated 2/20/17, regarding involvement in out of room activities, revealed the resident required one to one interaction related to poor mobility and poor cognition. The interventions indicated the resident would receive one to one visits in his room two to three times a week. The One-To-One/Small Group Attendance Record form, initiated on 2/13/17, revealed the resident only received one to one visits three times in February, four times in March, four times in April, four times in May, five times in June and four times in July R#59 was observed on 7/31/17 at 4:30 p.m. in bed and alone. The resident was further observed in bed and alone on 8/1/17 at 9:00 a.m., 8/1/17 at 12:00 p.m., on 8/1/17 at 2:00 p.m., and on 8/1/17 at 5:00 p.m. R#59 was not engaged in any one to one or out of room activities at these times. An interview with the Recreational Service Director (RSD) on 8/2/17 at 8:15 a.m. verified the resident did not get out of bed for activities. She verified he required extensive care by the staff. The RSD stated the resident was to receive two to three, one to one visits per week from activities. The RSD verified the activity log reflected activities from February 2017 to the present indicated the resident only received one to one visits three to five times a month and did not attend any out of room activities. An interview on 8/3/17 at 12:30 p.m., with the nurse consultant (NC), who was a registered nurse (RN), verified the resident did not receive two to three one to one visits each week as per the plan of care.
F 0279 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and record review, the facility failed to develop a care plan which include person-centered objectives and interventions to address the use of a wearable, external defibrillator for one resident (R#188) out of 29 sampled residents reviewed. The failure resulted in staff not being aware of the medical device; specific instructions as to what to do after the defibrillator (Life Vest) discharges and precautions to avoid accidental shocks. Those failures placed the resident at risk of immediate harm and potential death. Cross reference F328. Findings include: Review of R#188's Admission Minimum Data Set (MDS), dated [DATE], indicated under Section B, items B0700 and B0800 the resident was able to both understand others and make himself understood. Section C, item C0500 specified his Brief Interview Mental Status (BIMS) Summary Score was a 15 out of 15, which indicated he was cognitively intact. Section C, item C1310 indicated the resident had no signs or symptoms of [MEDICAL CONDITION] or acute mental status change. Section D, item D0300 indicated R#188's Total (Mood) Severity Score was 0 which indicated no depression. Section E, items E0100 through E1100 indicated the resident exhibited no signs or symptoms of [MEDICAL CONDITION] or behavioral symptoms (expressions of distress), and no rejection of care or wandering during the assessment's evaluation periods. R#188 was coded as being totally dependent on staff for all Activities of Daily Living (ADLs) which included bathing, dressing and grooming. Life Vest Definition: A Life Vest is a wearable, external defibrillator that is a treatment option for sudden [MEDICAL CONDITION] (SCA) that offers patients advanced protection and monitoring as well as improved quality of life. It is worn outside the body (as opposed to an implantable cardioverter defibrillator (ICD). It continuously monitors the patient's heart with dry, non-adhesive [MEDICATION NAME] to detect life-threatening abnormal heart rhythms. If a life-threatening rhythm is detected, the device alerts the patient prior to delivering a treatment shock, and thus allows a conscious patient to delay the treatment shock. If the patient becomes unconscious, the device releases a Blue gel over the therapy [MEDICATION NAME] and delivers an electric shock to restore normal rhythm. The patient needs to be seen at the Emergency Department, to be evaluated by a cardiologist, following a treatment shock and the vest has to be reloaded with new [MEDICATION NAME], as they only release Blue gel once. A subsequent shock without reloading could result in a failed shock and skin burns. Observation of R#188 on 7/31/17 at 5:45 p.m., revealed him to be asleep in his room. He was observed to have a thick black strap around his neck, to which a black monitor (approximately 5.0 x 6.0 x 1.5 inches) was attached. During a family interview on 7/31/17 at 6:10 p.m., indicated R#188 had a Life Vest on and had been applied during his cardiology appointment on 7/27/17. Record review of R#188's clinical record revealed there was no physicians order for the device; it was not on his care plan (initiated 7/20/17 and updated 7/28/17 and 7/31/17) and nowhere in the Progress Notes was there any mention of the device. Multiple interviews with staff (Cross reference F328) proved at least some were aware of the device and either did not ask what the device was, and/or report the device to the nursing staff. The Administrative Staff (The Director of Nursing, The Administrator and the Nurse Consultant) nor the resident's Attending Physician (who was also the Medical Director), were aware the medical device was in place for five days until notified by the surveyor. By not identifying the medical device (external defibrillator, Life Vest) placed on R#188 and not developing an appropriate plan of care, the facility failed to ensure direct care staff were aware and knowledgeable on how to monitor and care for R#188; which placed him at risk of serious harm and potential death. A Credible Allegation of Compliance was received on 8/3/17. Based on observations, record reviews, interviews and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated the corrective plans and the immediacy of the deficient practice was removed on 8/3/17. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of resident assessment procedures to ensure any equipment a resident received was physician-ordered; all direct care staff were trained in the proper use/oversight of said medical equipment; and a policy/procedure was instituted to address the use (specifically) of an external defibrillator. This oversight process included the analysis of in-service materials and records on 8/3/17. Interviews were conducted with staff on 8/3/17 to ensure they demonstrated knowledge of facility Policies and Procedures governing external defibrillators. The resident's record was reviewed on 8/3/17 to ensure resident care and treatment, including physician

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

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F 0279 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) orders [REDACTED]. All verification was confirmed by facility staff interviews, documentation and clincal record reviews. Allegation of Compliance Verification as follows: 1. Immediate Action Taken for Residents: 8/2/2017 at 12:00 p.m. 'Zoll Life Vest Company' did an In-Service for all working staff. In-services continue by the 'Clinical Nurse Consultant (CNC) and the Director of Nursing Services (DNS).' No staff will return to work until in serviced on 'Life Vest' and following up on doctors' orders. 'Zoll Life Vest Company' completed assessment of resident R#188 on 8/2/2017. This was verified via interview with the Life Vest Technician on 8/2/17 at approximately 2:30 p.m. Then on 8/2/17 at 4:00 p.m. the Nurse Consultant provided copies of the training outline as well as a list of direct care staff that had obtained training that day. The NC also confirmed no direct care staff would be allowed to work again until they had one to one training from either the NC or DON. A 100% audit was completed 8/2/17 to assure no other residents had an external defibrillator. All residents will be assessed upon admission to facility for external defibrillator. This was verified and confirmed through the interview with the NC on 8/2/17 at 4:00 p.m., all residents residing in the facility were checked for medical devices including any external defibrillator devices and no other resident was identified having such said device. Care Plan was updated 8/2/17 for R#188 to include Life Vest. This was verified and confirmed on 8/2/17 at 4:00 p.m. by review of the actual care plan for R#188. Activities of Daily Living (ADL) care record was updated on 8/2/17 R#188 to reflect Life Vest. This was verified and confirmed 8/2/17 at 4:00 p.m. by review of the actual ADL Care Record for R#188. Life Vest Information pamphlet in Medication Administration Record [REDACTED]. This was verified and confirmed on 8/2/17 by surveyor ensuring these things were in place on the MAR, ADL care record and R#188's closet door. Facility Clinical Start Up form will be used at 9:00 a.m. meeting to ensure follow up of all Medical Doctor (MD) appointments and all MD orders. This future implementation was verified to be put in place by interviews with the facility administration staff members. No form was made available, as it was a part of the Plan of Correction going forward. 2. Action taken to assure no other residents will be affected in the future: An immediate audit of 100% of resident's charts began on 8/2/17 to ensure all MD follow up orders have been implemented. This was verified and confirmed via interview with the NC on 8/2/17 at 4:00 p.m. the Nurse Consultant provided copies of training outline as well as a list of direct care staff that had obtained training that day. The NC also stated no direct care staff would be allowed to work again until they had one to one training from either the NC or DON. 8/2/17 In-Service on LifeVest to ensure training was given to all direct care staff. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. Training outline to reflect Life Vest care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. In-service staff on proper follow up for all MD appointments. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. Training outline to reflect Life Vest care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. 3. Monitoring: R#188 was put on one to one until all staff were in-serviced on LifeVest. This was done prior to the AOC and eduation done by the Life Vest Technician on 8/2/17 at 12:00 p.m. The faciliy made the surveyor aware after the fact. DNS and CNC will audit 10% of MD follow up appointment for one week. Then DHS and/or CNC will complete a random audit of doctor's appointment follow up orders weekly for four weeks. This was part of the going forward Plan of Correction. Facility will continue to monitor our performance improvement plan monthly in QAPI meetings. This was part of the going forward Plan of Correction.
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and staff and resident interviews, the facility failed to provided two of 29 sampled residents (R#194, R#48), who were identified as cognitively impaired and independently mobile, with required supervision when toileting and an environment free from potential accident hazards. The handrails in R#194's bathroom was not secured to the wall and there were no emergency cords for public restrooms that were accessible to residents. This deficient practice had the potential to allow for injury to any resident that used a grab bar in residents' restrooms, or any resident that was able to get into the public restrooms. Findings include: 1. During an interview on 7/31/17 at 12:00 p.m., with R#194, the resident stated that he was in the facility for rehabilitation after falling at home and had fractured ribs. R#194 stated that after using the restroom in his room, he went to use the grab bar on the wall next to the toilet to help him stand up, and the grab bar pulled out from the wall. R#194 also stated that he had reported it to the nurse when it happened on 7/28/17. Observation in the resident's restroom at that time (7/31/17 at 12:00 p.m.) revealed that the grab bar had pulled out of the wall and was unable to be used to assist with sitting down on or getting up from the toilet. During an interview with the Maintenance Supervisor, on 7/31/17 at 3:17 p.m., he stated that he was unaware of the loose grab bar until this morning when he saw it in his work book. He checked it and stated he would remove the grab bar from the wall. He also stated there had been a remodel done in the facility in 2008 and that all the grab bars in the residents' restrooms would be checked. On 8/3/17 at 2:00 p.m., the Maintenance Supervisor provided a document titled Bathroom Grab Bar Check List, dated 8/3/17, showing that all of the grab bars in the residents' restrooms on the 100 hall had been checked, and found that 50% of those bars were not anchored to wall studs or a backer board. 2. A review of R #48's face sheet, dated 1/16/17, revealed [DIAGNOSES REDACTED]. R #48's care plan, dated 8/17/16, indicated the resident had intermittent confusion, increased forgetfulness and short-term memory impairment related to dementia. The care plan further indicated the resident declined redirection to a bathroom with a safe environment. The resident declined to use a bathroom with a pull cord. The interventions included to redirect (the) resident to (the) bathroom in his room with (a) pull cord and to assist (the) resident to his (own) room when needed to assist with the use of the bathroom. The minimum data set (MDS) quarterly assessment, dated 05/24/17, indicated the facility was unable to assess the resident's cognition. Note: The MDS is an assessment tool used for residents in nursing homes. The MDS, section G, titled Functional Status, revealed the resident required extensive assistance for toileting and transfers, limited assistance with locomotion off the unit and he was always incontinent. The resident was observed in the public men's restroom in the lobby of the facility on 8/1/17 at 11:30 a.m., by the recreational services director (RSD), while the surveyor was present. The resident was in the bathroom in the wheelchair alone with the door closed. There was a staff person at the reception desk. There was no emergency call light in the bathroom. An interview with the RSD, on 8/1/17 at 2:45 p.m., verified R #48 was in the lobby bathroom alone in the wheelchair at 11:30 a.m. She verified there were no emergency call lights in the bathrooms in the lobby of the facility. She stated residents were not supposed to use the public restrooms in the lobby. She verified the bathrooms were not kept locked. An interview with the Nurse Consultant, who was a registered nurse (RN), on 8/2/17 at 10:15 a.m. revealed R #48 had a care plan that addressed the resident's preference to use the bathroom in the lobby, which had no emergency call light. She stated the two bathrooms in the lobby were not kept locked. The nurse consultant further revealed the intervention for the behavior was to redirect the resident to a safe area for toileting. She verified the resident required assistance for toileting and transferring and did not toilet himself. The Nurse Consultant indicated R#48 had not been redirected the day he was found in the lobby bathroom alone.
F 0328 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot**

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F 0328 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) **care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff, resident and family interviews, and record reviews the facility failed to ensure one resident (R#188) from a total of 29 sample residents received the necessary care and treatment including medical and nursing care services for the use and monitoring of a specialized device; an external defibrillator. The facility Administrative Staff (Director of Nursing, Nurse Consultant, Administrator nor his Attending Physician (whom was also the Medical Director) were unaware of the Life Vest being applied on R#188 which placed him at risk because; an immediate follow up with a cardiologist was required when the Life Vest needed to be reloaded after a treatment shock. A subsequent discharge from the Life Vest could be ineffective, and could result in death, and potentially cause serious skin burns. Staff were being placed at risk for incidental shocks by not having appropriate training and education. R#188 was in immediate danger of injury or death due to the facility's failures. Findings include: Resident (R) #188 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A normal ejection fraction ranges from 55 - 70%. An EF of 20 indicates heart failure). He was determined to have severe 3 vessel [MEDICAL CONDITION] but was deemed a poor surgical candidate due to [MEDICAL CONDITION] viability and a Life Vest (A Life Vest is a wearable, external defibrillator that is a treatment option for sudden [MEDICAL CONDITION] (SCA) that offers patients advanced protection and monitoring as well as improved quality of life) was placed on 7/17/17, then removed due to a suture preventing appropriate skin contact. It was replaced on 7/27/17 at the cardiologist's office. Review of R#188's Admission Minimum Data Set (MDS), dated [DATE], it indicated under Section B, items B0700 and B0800 that the resident was able to both understand others and make himself understood. Section C, item C0500 specified his Brief Interview Mental Status (BIMS) Summary Score was a 15 out of 15, which indicated he was cognitively intact. Section C, item C1310 indicated the resident had no signs or symptoms of [MEDICAL CONDITION] or acute mental status change. Section D, item D0300 indicated R#188's Total (Mood) Severity Score was 0 which indicated no depression. Section E, items E0100 through E1100 indicated the resident exhibited no signs or symptoms of [MEDICAL CONDITION] or behavioral symptoms (expressions of distress), and no rejection of care or wandering during the assessment's evaluation periods. He was coded as being totally dependent on staff for all Activities of Daily Living (ADLs) which included bathing, dressing and grooming. Life Vest Definition: A Life Vest is a wearable, external defibrillator that is a treatment option for sudden [MEDICAL CONDITION] (SCA) that offers patients advanced protection and monitoring as well as improved quality of life. It is worn outside the body (as opposed to an implantable cardioverter defibrillator (ICD). It continuously monitors the patient's heart with dry, non-adhesive [MEDICATION NAME] to detect life-threatening abnormal heart rhythms. If a life-threatening rhythm is detected, the device alerts the patient prior to delivering a treatment shock, and thus allows a conscious patient to delay the treatment shock. If the patient becomes unconscious, the device releases a Blue gel over the therapy [MEDICATION NAME] and delivers an electric shock to restore normal rhythm. The patient needs to be seen at the emergency department, to be evaluated by a cardiologist. Following a treatment shock the vest would have to be reloaded with new [MEDICATION NAME], as they only release Blue gel once. A subsequent shock without reloading could result in a failed shock and skin burns. On 7/31/17 4:55 p.m., during an attempt to do a resident interview as part of survey process, a large (approximately 5.1 x 6.125 X 1.6 inches) monitor of some sort was observed to be around R#188's neck, with a black strap. Review of R#188's clinical record, revealed no documentation either in Progress Notes, Physician Orders or the Care Plan regarding the device. A subsequent telephone interview on 7/31/17 at 6:10 p.m., with the family of R#188 (as he was initially not available due to sleeping and in therapy) revealed it was a Life Vest monitor. The family member stated R#188 had the device prior to being admitted to the facility, but upon discharge from the hospitalization (6/18/17 - 7/18/17) it was determined the Life Vest could not be applied until the sutures were removed. The family member stated it was reapplied on 7/27/17 while R#188 was at his cardiologist. The family member stated she had discussed the device with the nurse on duty (several phone messages to that nurse went unreturned). The nurse told the family member she had heard of the Life Vest but had no experience with it and had not been trained in its use. Further review of R#188's clinical record, revealed the nurse did not document the device being in place, or completed any type of assessment of R#188 upon his return from the cardiologist. There was no documented evidence the facility tried to follow up by phone with the cardiologist. A record review of the Care Plan for R#188, initiated 7/20/17, with updates noted 7/28/17 and 7/31/17, revealed there was no mention of the resident having a Life Vest in place. There was no documentation in the Progress Notes, by nursing, indicating the presence of the Life Vest. There was no physician's order for the use of [REDACTED] A review of the Bathing records revealed the following bathing assistance was provided to R#188. Out of the six Certified Nursing Assistants (CNA) who documented bathing the resident from 7/27/17 through 8/1/17, four were interviewed regarding observations made after 7/27/17, when the Life Vest was applied. The results were as follows: 1. CNA DD documented bathing care was given on 7/27/17 and was a bed bath, 7/31/17 as a shower, and 8/1/17 as a bed bath. An interview with CNA DD on 8/3/17 at 8:03 a.m., revealed She gave R#188 a bed bath sometime last week and she saw the vest and pack and thought the facility knew about it. She indicated she did not ask questions or report it to the facility. She further indicated she was not told he had a vest on and the charge nurse should advise if there was a change in care for the resident. 2. CNA BB documented bathing care was given on 7/27/17 and was a bed bath, and 7/28/17 as a bed bath. An interview with CNA BB on 8/2/17 at 5:25 p.m., revealed she did not ask what the battery pack was for and she would assume the nurse knew the resident had the vest from resident assessment because it was around his neck. CNA BB indicated she gave him a bed bath and did not report the battery pack to the facility. 3. CNA CC documented bathing care was given on 7/30/17 and was a sponge bath. An interview with CNA CC on 8/2/17 at 5:45 p.m., revealed she did not remember the resident and she had not provided care for him. She indicated she let a new CNA use her number to chart because she did not have a number yet, and that was why she showed up as having given R#188 a bed bath. 4. CNA AA documented bathing care was given on 7/31/17 and was a bed bath. An interview with CNA AA on 8/2/17 at 5:30 p.m., revealed she gave R#188 a bed bath and he had a vest on. She further indicated she did not ask resident about pack and confirmed he had the vest on when she gave him a bath. She continued to indicate she did not ask the nurses about the pack and stated the nurses did not ask or talk to the CNA's regarding the pack. An interview with the Director of Nursing (DON) and the facility Nurse Consultant (NC) on 8/2/17 at 10:30 a.m., revealed neither of them were aware R#188 had the Life Vest on. The NC indicated it was facility protocol for anything unusual (like a change in condition, the appearance of unidentified medical equipment, etc.) was to be immediately documented on a form they used entitled Stop and Watch form (A 2-part form where changes regarding the resident were to be noted then passed on to nursing; or be documented on their 24-hour Report). They further revealed R#188's Life Vest was never reported in Morning Stand Up 9:00 a.m. meeting. Further interview with the DON and the NC revealed they both indicated their surprise that no one had reached out in the five days since R#188 had the vest placed, to follow up with nursing and/or the physician. They continued to indicate both had heard of the Life Vest but had not had specific training regarding its use and/or oversight required for both resident and staff safety. The DON revealed they sent paperwork with all residents when they go to a doctor's appointment (which consisted of a face sheet, current Medication Administration Records (MARs), and blank Progress Notes). The NC indicated it was the facility's expectation the physician's office document any treatments or new orders on the provided Progress Notes. She further revealed they did not receive anything back from the cardiologist visit on 7/27/17 and no one called the cardiologist's office to inquire if there were any changes or new orders. An interview with LPN GG on 8/2/17 at 11:45 a.m., revealed information regarding a conversation with the NC. The NC had stated one nurse on the hall R#188 resided on had been trained in the use and oversight of the Life Vest at a sister facility. The surveyor interviewed LPN GG and she stated she did not have any training in the use or oversight of the Life Vest. When advised of the discrepancy, the NC went to LPN GG, with the surveyor, and suggested she had the training (and named the facility). LPN GG indicated she had never worked at the sister facility and maintained she had never been trained on the Life Vest.

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F 0328 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) On 8/2/17 at approximately 1:30 p.m., the NC indicated after researching the situation with R#188, she determined what had happened was a family member brought the Life Vest in the facility on 7/27/17 after R#188 returned from his doctor and the family had placed the vest on the resident. Further investigation revealed the vest was placed during the 7/27/17 cardiologist visit, for which the facility provided transportation for R#188. On 8/2/17 at 2:00 p.m., revealed the DON previously independently interviewed his staff and provided the surveyor with the following results: Out of six CNAs, eight LPNs and one RN, he documented 11 of 15 staff members did not notice the device at all, and four staff members seen it and did not report it to anyone. He did express his disappointment in the lack of communication. An interview with the Licensed Physical Therapy Assistant (LPTA) on 8/2/17 at 3:45 p.m., revealed the LPTA overseen R#188's therapy program. He indicated he saw the device on 7/28/17 and reported to his supervisor. The LPTA further indicated he assumed the nursing staff were aware of the device. When asked if he was familiar with the Life Vest, as far as the purpose of and what sort of safety/oversight measures might be required, he stated, I am not. The therapists were contracted and not direct employees of the facility. A telephone interview with the Therapy Department Manager (TDM) on 8/3/17 at 9:45 a.m., revealed she confirmed the LPTA did report to her R#188 did have a Life Vest. She also revealed she too assumed if he had the device on, nursing was aware. She further indicated she did not report it to any other staff member or review R#188's clinical record to obtain additional information about the device. When asked if she was familiar with the Life Vest, as far as the purpose of and what sort of safety/oversight measures might be required, she stated she was not. An interview with the Administrator on 8/2/17 at 3:45 p.m., revealed she was unaware R#188 had a Life Vest on and she was not familiar with its use or required safety and oversight. She also stated the facility did not have a policy or procedure in place to address the use of external defibrillators. She further revealed it was the facility protocol for staff to use the Stop and Watch form to document changes in condition, which would include an observation of medical equipment not otherwise noted. They did not have a written policy for the use of the Stop and Watch form. The Zoll Life Vest Technician (LVT) came to the facility on [DATE] at 12:00 p.m., and revealed she had come to the facility to provide training for staff regarding the use and oversight of the Life Vest at the request of the Nurse Consultant (NC). Once advised of the issue regarding the staff being unaware of the Life Vest use, the NC independently arranged for a technician from the medical equipment provider (Zoll) to come out and do a training in-service for all direct care staff. After she provided the training to staff the surveyor met with her. An interview with the LVT on 8/2/17 at 2:30 p.m., revealed she had come to the facility to provide training for staff regarding the use and oversight of the Life Vest at the request of the NC. She further indicated the resident did have a Life Vest on he had used prior to hospitalization (6/18 - 7/18/17). She revealed she was given the assignment to see the resident on 7/22/17 and revealed she was not aware he was in a 'Skilled Nursing Facility (SNF) and thought she was seeing him at home. Due to the suture, still being in place (from chest tube placement while hospitalized) she was unable to place the Life Vest. The LVT indicated she did not communicate with the facility because the resident was supposed to independent with the Life Vest. The LVT further indicated she went to see R#188 on 7/27/17 at the cardiologist appointment. R#188's family member had possession of the vest (from prior to the admission to the facility use) and brought it to the appointment. The technician revealed she measured the resident and determined the vest was the correct size. She placed it on R#188 and left the office. She further indicated it was meant to be used independently by a patient and R#188 was aware of how to use it. She explained when the monitor (of the Life Vest) detects an abnormal rhythm of the heart it alarms and warns the patient. They have 20 seconds to press two buttons simultaneously to stop the shock. If the patient does not stop it will shock. If the vest was not fitting properly it can generate artifact that will make the monitor think it needs to shock them. If the patient was unconscious the unit will provide the charge. There are conductor pads inside the vest that open and release a Blue gel (that acts as a skin protectant to prevent [MEDICAL CONDITION] the defibrillator and increased conductivity). The LVT revealed patients are directed to go to the emergency department to be evaluated by a cardiologist after the vest provides a charge. Then the emergency department (Life Vest provider) will reload the vest with new [MEDICATION NAME]. She also revealed patients are taught how to change the batteries if needed. R#188 also had an extra vest so one can be cleaned while he still had another one. The only time the patient should remove the vest was while showering or bathing. When the LVT came to facility 8/2/17 to provide the staff education, the family of R#188 wanted her to stop in and see the resident. She advised the family member she could not without an order. The family called and had an order sent by physician. The LVT did go and meet with the resident. She returned to report on the visit. She stated R#188 was quite defensive and rude with her, indicating he was very frustrated with all of the attention he was getting today regarding the Life Vest. Due to the facility, not being aware of when the Life Vest was applied, the LVT indicated we could reach out to the company office and they would provide a Wear Time Histogram (detailed graph showing when R#188 was wearing the Life Vest and it was in proper working order). Once received, it confirmed the vest was placed in the cardiologist's office on 7/27/17 and it remained in use as of 8/1/17. The LVT further confirmed it was still working on 8/1/17 through her visit on 8/2/17 as well. When asked if there could be any potential danger to staff or bystanders regarding the Life Vest if it discharged , the LVT stated, yes, a person could sustain a shock if they touched him while a treatment shock was in progress and the fact the facility staff were unaware R#188 would need to go to the hospital to be re-evaluated and would need the Life Vest reloaded, put R#188 at risk of serious harm or death. On 8/2/17 at 4:00 p.m. revealed the NC had a representative from the Life Vest provider come to the facility and provide an in-service for all direct care staff on duty. The in-service covered the use, the required oversight (which included the expected facility response to ensure follow up at an emergency department) as well as safety precautions to prevent staff being inadvertently shocked by the defibrillator should it discharge. The NC indicated between herself and the DON, training was provided and documentation to confirm all of the direct care staff on duty had received the training in the proper use and oversight of the Life Vest (handouts and written directives and pictures were provided). The NC stated no direct care staff would be allowed to work until they had received the training from either the NC or DON. A telephone interview with the Medical Director, who was also the Attending Physician for R#188, on 8/2/17 at 6:15 p.m., revealed he had been the Medical Director of the facility for approximately three years. When asked if he was familiar with the Life Vest, he indicated he was. He further revealed he was not aware R#188 had a Life Vest. He continued to reveal he was familiar with it and indicated he was surprised the resident had it applied and had been wearing it for five days without any facility staff intervention, including him being notified. The Medical Director also indicated he was not aware of any specific policy or procedures the facility had regarding the use of a Life Vest. Continued interview with the Medical Director revealed, when asked, what would he think the facility policy should address regarding the use of a Life Vest, he stated, In general it should allow for training, specifically any special safety instructions and required follow up that may be needed. When the Medical Director was made aware of the fact several facility staff members were aware R#188 had the Life Vest and had not reported nor documented it, his response was surprise and he stated, That was not what I was told. He indicated the facility staff had told him no one knew R#188 had the Life Vest until it was identified by the surveyor. A Credible Allegation of Compliance was received on 8/3/17. Based on observations, record reviews, interviews and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated the corrective plans and the immediacy of the deficient practice were removed on 8/3/17. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of resident assessment procedures to ensure any equipment a resident received was physician-ordered; all direct care staff were trained in the proper use/oversight of said medical equipment; and a policy/procedure was instituted to address the use (specifically) of an external defibrillator. This oversight process included the analysis of in-service materials and records on 8/3/17. Interviews were conducted with staff on 8/3/17 to ensure they demonstrated knowledge of facility Policies and Procedures governing external defibrillators. The resident's record was reviewed on 8/3/17 to ensure resident care and treatment, including physician orders for external defibrillator therapy, were current and accurate. All verification was confirmed by facility staff interviews, documentation and clincal record reviews. Allegation of Compliance Verification as follows: 1. Immediate Action Taken for Residents: 8/2/2017 at 12:00 p.m. 'Zoll LifeVest Company' did an In-Service for all working staff. In-services continue by the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0328 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 4) 'Clinical Nurse Consultant (CNC) and the Director of Nursing Services (DNS).' No staff will return to work until in serviced on 'LifeVest' and following up on doctors' orders. 'Zoll LifeVest Company' completed assessment of resident R#188 on 8/2/2017. This was verified via interview with the 'Life Vest Technician' on 8/2/17 at approximately 2:30 p.m. Then on 8/2/17 at 4:00 p.m. the 'Nurse Consultant' provided copies of the training outline as well as a list of direct care staff that had obtained training that day. The NC also confirmed no direct care staff would be allowed to work again until they had one to one training from either the NC or DON. A 100% audit was completed on 8/2/17 to assure no other residents had an external defibrillator. All residents will be assessed upon admission to facility for external defibrillator. This was verified and confirmed through the interview with the NC on 8/2/17 at 4:00 p.m., all residents residing in the facility were checked for medical devices including any external defibrillator devices and no other resident was identified having such said device. Care Plan was updated 8/2/17 for R#188 to include LifeVest. This was verified and confirmed on 8/2/17 at 4:00 p.m. by review of the actual care plan for R#188. Activities of Daily Living (ADL) care record was updated on 8/2/17 R#188 to reflect LifeVest. This was verified and confirmed 8/2/17 at 4:00 p.m. by review of the actual ADL Care Record for R#188. LifeVest Information pamphlet in Medication Administration Record [REDACTED]. This was verified and confirmed on 8/2/17 by surveyor ensuring these things were in place on the MAR, ADL care record and R#188's closet door. Facility Clinical Start Up form will be used at 9:00 a.m. meeting to ensure follow up of all Medical Doctor (MD) appointments and all MD orders. This future implementation was verified to be put in place by interviews with the facility administration staff members. No form was made available, as it was a part of the Plan of Correction going forward. 2. Action taken to assure no other residents will be affected in the future: An immediate audit of 100% of resident's charts began on 8/2/17 to ensure all MD follow up orders have been implemented. This was verified and confirmed via interview with the NC on 8/2/17 at 4:00 p.m. the Nurse Consultant provided copies of training outline as well as a list of direct care staff that had obtained training that day. The NC also stated no direct care staff would be allowed to work again until they had one to one training from either the NC or DON. 8/2/17 In-Service on 'LifeVest' to ensure training was given to all direct care staff. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. Training outline to reflect Life Vest care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. In-service staff on proper follow up for all MD appointments. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. Training outline to reflect Life Vest care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. 3. Monitoring: R#188 was put on one to one until all staff were in-serviced on LifeVest. This was done prior to the AOC and education done by the Life Vest Technician on 8/2/17 at 12:00 p.m. The facility made the surveyor aware after the fact. DNS and CNC will audit 10% of MD follow up appointment for one week. Then DHS and/or CNC will complete a random audit of doctor's appointment follow up orders weekly for four weeks. This was part of the going forward Plan of Correction. Facility will continue to monitor our performance improvement plan monthly in QAPI meetings. This was part of the going forward Plan of Correction.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility was not administered in an effective manner, utilizing all its resources, resulting in Immediate Jeopardy creating the likelihood of death or serious harm to one of 29 sampled residents (R#188) residing in the facility. The Administrator did not ensure all residents were protected from potential hazards related to unsafe oversight, or lack of, in regard to the use of an external defibrillator; failure to provide appropriate education to all direct care staff in the use of external defibrillators; and failure to ensure external defibrillator oversight policies were developed, implemented and reviewed in the Quality Assurance (QA) program. The sampled size was 29 residents at the time of the survey and one resident (R#188) currently at risk of immediate injury and potential death. Cross reference F328. This deficient practice resulted in an Immediate Jeopardy to R#188's safety, which began on 7/27/17 when R#188 had the Life Vest applied during a cardiology appointment. The Administrator, the Nurse Consultant (NC) and Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/3/17 at 9:35 a.m. The Immediate Jeopardy was considered abated as of 2:35 p.m., on 8/3/17, as they had submitted an acceptable plan to remove the IJ related to F328. Findings include: 1. Observations, staff interviews, and record review revealed the facility was not in substantial compliance during the recertification survey of 7/31/17 - 8/4/17. Refer to the following deficiencies for specific details of the noncompliance: a. Comprehensive Care Plans: 483.21 F279 - Failure to develop a care plan to indicate the use of an external defibrillator for R#188. b. Treatment /Care for Special Needs: 483.25 F328 - Failure to ensure R#188 received appropriate external defibrillator care and monitoring from staff caring for R#188 and ensure proper oversight and training was provided to direct care staff that would interact with the Life Vest. c. Administration: 483.70 F490 - Failure to ensure the facility was administered in an effective manner related to the use and care of an external defibrillator for R#188 by failing to ensure the Medical Director was aware of the requirement for developing and implementing policies and procedures for the use of an external defibrillator; ensure all residents had been assessed to determine whether or not they returned from outside appointments with any new medical devices, and to ensure they received documentation of physician's visits, as to new orders and status from the visit; ensure staff were aware of reporting protocol for changes in condition (including new medical devices put in place); and ensure there was a written policy to address the expected use of the Stop and Watch form. F501 - Failure to assist the facility in the development and implementation of a policy and procedure related to the use and care of an external defibrillator. d. Quality Assurance & Performance Improvement: 483.75 F520 - Failure to ensure a Quality Assurance (QA) for external defibrillator use was developed and implemented. Life Vest Definition: A Life Vest is a wearable, external defibrillator that is a treatment option for sudden [MEDICAL CONDITION] (SCA) that offers patients advanced protection and monitoring as well as improved quality of life. It is worn outside the body (as opposed to an implantable cardioverter defibrillator (ICD). It continuously monitors the patient's heart with dry, non-adhesive [MEDICATION NAME] to detect life-threatening abnormal heart rhythms. If a life-threatening rhythm is detected, the device alerts the patient prior to delivering a treatment shock, and thus allows a conscious patient to delay the treatment shock. If the patient becomes unconscious, the device releases a Blue gel over the therapy [MEDICATION NAME] and delivers an electric shock to restore normal rhythm. The patient needs to be seen at the Emergency Department, to be evaluated by a cardiologist, following a treatment shock and the vest has to be reloaded with new [MEDICATION NAME], as they only release Blue gel once. A subsequent shock without reloading could result in a failed shock and skin burns. An interview with the Administrator on 8/2/17 at 3:45 p.m., revealed she was unaware R#188 had a Life Vest on and she was not familiar with its use or required safety and oversight. She also stated the facility did not have a policy or procedure in place to address the use of external defibrillators. She further revealed it was the facility protocol for staff to use the Stop and Watch form to document changes in condition, which would include an observation of medical equipment not otherwise noted. They did not have a written policy for the use of the Stop and Watch form. A Credible Allegation of Compliance was received on 8/3/17. Based on observations, record reviews, interviews and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated the corrective plans and the immediacy of the deficient practice was removed on 8/3/17. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of resident assessment procedures to ensure any

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F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 5) equipment a resident received was physician-ordered; all direct care staff were trained in the proper use/oversight of said medical equipment; and a policy/procedure was instituted to address the use (specifically) of an external defibrillator. This oversight process included the analysis of in-service materials and records on 8/3/17. Interviews were conducted with staff on 8/3/17 to ensure they demonstrated knowledge of facility Policies and Procedures governing external defibrillators. The resident's record was reviewed on 8/3/17 to ensure resident care and treatment, including physician orders [REDACTED]. All verification was confirmed by facility staff interviews, documentation and clincal record reviews. Allegation of Compliance Verification as follows: 1. Immediate Action Taken for Residents: 8/2/2017 at 12:00 p.m. 'Zoll LifeVest Company' did an In-Service for all working staff. In-services continue by the 'Clinical Nurse Consultant (CNC) and the Director of Nursing Services (DNS).' No staff will return to work until in serviced on 'LifeVest' and following up on doctors' orders. 'Zoll LifeVest Company' completed assessment of resident R#188 on 8/2/2017. This was verified via interview with the Life Vest Technician on 8/2/17 at approximately 2:30 p.m. Then on 8/2/17 at 4:00 p.m. the Nurse Consultant provided copies of the training outline as well as a list of direct care staff that had obtained training that day. The NC also confirmed no direct care staff would be allowed to work again until they had one to one training from either the NC or DON. A 100% audit was completed 8/2/17 to assure no other residents had an external defibrillator. All residents will be assessed upon admission to facility for external defibrillator. This was verified and confirmed through the interview with the NC on 8/2/17 at 4:00 p.m., all residents residing in the facility were checked for medical devices including any external defibrillator devices and no other resident was identified having such said device. Care Plan was updated 8/2/17 for R#188 to include Life Vest. This was verified and confirmed on 8/2/17 at 4:00 p.m. by review of the actual care plan for R#188. Activities of Daily Living (ADL) care record was updated on 8/2/17 R#188 to reflect Life Vest. This was verified and confirmed 8/2/17 at 4:00 p.m. by review of the actual ADL Care Record for R#188. Life Vest Information pamphlet in Medication Administration Record [REDACTED]. This was verified and confirmed on 8/2/17 by surveyor ensuring these things were in place on the MAR, ADL care record and R#188's closet door. Facility Clinical Start Up form will be used at 9:00 a.m. meeting to ensure follow up of all Medical Doctor (MD) appointments and all MD orders. This future implementation was verified to be put in place by interviews with the facility administration staff members. No form was made available, as it was a part of the Plan of Correction going forward. 2. Action taken to assure no other residents will be affected in the future: An immediate audit of 100% of resident's charts began on 8/2/17 to ensure all MD follow up orders have been implemented. This was verified and confirmed via interview with the NC on 8/2/17 at 4:00 p.m. the Nurse Consultant provided copies of training outline as well as a list of direct care staff that had obtained training that day. The NC also stated no direct care staff would be allowed to work again until they had one to one training from either the NC or DON. 8/2/17 In-Service on LifeVest to ensure training was given to all direct care staff. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. Training outline to reflect Life Vest care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. In-service staff on proper follow up for all MD appointments. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. Training outline to reflect Life Vest care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. 3. Monitoring: R#188 was put on one to one until all staff were in-serviced on LifeVest. This was done prior to the AOC and eduation done by the Life Vest Technician on 8/2/17 at 12:00 p.m. The faciliy made the surveyor aware after the fact. DNS and CNC will audit 10% of MD follow up appointment for one week. Then DHS and/or CNC will complete a random audit of doctor's appointment follow up orders weekly for four weeks. This was part of the going forward Plan of Correction. Facility will continue to monitor our performance improvement plan monthly in QAPI meetings. This was part of the going forward Plan of Correction.
F 0501 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Choose a doctor to serve as the medical director to create resident care policies and coordinate medical care in the facility.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review the facility failed to ensure the Medical Director coordinated medical care in the facility including provision of clinical guidance and oversite for the implementation of resident care policies related to sampled resident (R#188). Specifically, the Medical Director failed to help develop, implement and evaluate resident care policies and procedures for the use of a wearable, external defibrillator. The sample size was 29 residents. Cross reference F328. Findings include: Resident (R) #188 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A normal ejection fraction ranges from 55% - 70%. An EF of 20 indicates heart failure). He was determined to have severe 3 vessel [MEDICAL CONDITION] but was deemed a poor surgical candidate due to [MEDICAL CONDITION] viability and a Life Vest (A Life Vest is a wearable, external defibrillator that is a treatment option for sudden [MEDICAL CONDITION] (SCA) that offers patients advanced protection and monitoring as well as improved quality of life) was placed on 7/17/17, then removed due to a suture preventing appropriate skin contact. It was replaced on 7/27/17 at the cardiologist's office. The facility Administrative Staff (Director of Nursing, Nurse Consultant, Administrator nor his Attending Physician (whom was also the Medical Director) were aware of the Life Vest being placed on R#188 which placed him at risk (as immediate follow up with a cardiologist was required; and the Life Vest needed to be reloaded after a treatment shock. A subsequent discharge could be ineffective, and could result in death, and potentially cause serious skin burns); as well as staff being at risk for incidental shocks by not having appropriate training and education. R#188, out of a census of 71 residents, was the only resident with an external defibrillator. He was in immediate danger of injury or death due to the facility's failures. Review of the contract between the facility and the Medical Director, dated June 2014, revealed the following, in pertinent parts: Duties and responsibilities of a Medical Director (Essential Functions). The Medical Director is responsible for implementation of resident care policies and the coordination of medical care in the facility. Specific duties and responsibilities . 1. Provide medical decision input to the Administrator and Governing Body of the facility. 1.1 Participate in developing resident care policies, as well as policies regarding services of physicians and other healthcare professionals providing treating the residents of the facility . 3.3 As set forth in this agreement, Medical Director shall review, respond to and participate in federal, stated. Local and other external surveys and inspections . 3.4 Medical Director shall at all times render Services in a competent, professional and ethical manner in accordance with prevailing standards of medical practice in the relevant community, perform professional and supervisory services in accordance with recognized standards of the medical profession. Review of R#188's Admission Minimum Data Set (MDS), dated [DATE], it indicated under Section B, items B0700 and B0800 that the resident was able to both understand others and make himself understood. Section C, item C0500 specified his Brief Interview Mental Status (BIMS) Summary Score was a 15 out of 15, which indicated he was cognitively intact. Section C, item C1310 indicated the resident had no signs or symptoms of [MEDICAL CONDITION] or acute mental status change. Section D, item D0300 indicated R#188's Total (Mood) Severity Score was 0 which indicated no depression. Section E, items E0100 through E1100 indicated the resident exhibited no signs or symptoms of [MEDICAL CONDITION] or behavioral symptoms (expressions of distress), and no rejection of care or wandering during the assessment's evaluation periods. He was coded as being totally dependent on staff for all Activities of Daily Living (ADLs) which included bathing, dressing and grooming. Life Vest Definition: A Life Vest is a wearable, external defibrillator that is a treatment option for sudden [MEDICAL CONDITION] (SCA) that offers patients advanced protection and monitoring as well as improved quality of life. It is worn outside the body (as opposed to an implantable cardioverter defibrillator (ICD). It continuously monitors the patient's heart with dry,

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F 0501 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 6) non-adhesive [MEDICATION NAME] to detect life-threatening abnormal heart rhythms. If a life-threatening rhythm is detected, the device alerts the patient prior to delivering a treatment shock, and thus allows a conscious patient to delay the treatment shock. If the patient becomes unconscious, the device releases a Blue gel over the therapy [MEDICATION NAME] and delivers an electric shock to restore normal rhythm. The patient needs to be seen at the Emergency Department, to be evaluated by a cardiologist, following a treatment shock and the vest has to be reloaded with new [MEDICATION NAME], as they only release Blue gel once. A subsequent shock without reloading could result in a failed shock and skin burns. A telephone interview with the Medical Director (also the Attending Physician) for R#188, on 8/2/17 at 6:15 p.m., revealed he had been the Medical Director of the facility for approximately three years. When asked if he was familiar with the Life Vest, he indicated he was. He further revealed he was not aware R#188 had a Life Vest. He continued to indicate he was familiar with it and was surprised the resident had it applied and had been wearing it for five days without any staff intervention, including him being notified. The Medical Director also indicated he was not aware of any specific policy or procedures the facility had regarding the use of a Life Vest. Continued interview with the Medical Director revealed, when asked, what he would think the facility policy should address regarding the use of a Life Vest, he stated, In general it should allow for training, specifically any special safety instructions and required follow up that may be needed. 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The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of resident assessment procedures to ensure any equipment a resident received was physician-ordered; all direct care staff were trained in the proper use/oversight of said medical equipment; and a policy/procedure was instituted to address the use (specifically) of an external defibrillator. This oversight process included the analysis of in-service materials and records on 8/3/17. Interviews were conducted with staff on 8/3/17 to ensure they demonstrated knowledge of facility Policies and Procedures governing external defibrillators. The resident's record was reviewed on 8/3/17 to ensure resident care and treatment, including physician orders [REDACTED]. All verification was confirmed by facility staff interviews, documentation and clincal record reviews. Allegation of Compliance Verification as follows: 1. 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Training outline to reflect 'Life Vest' care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. In-service staff on proper follow up for all MD appointments. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. Training outline to reflect Life Vest care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. 3. Monitoring: R#188 was put on one to one until all staff were in-serviced on LifeVest. This was done prior to the AOC and education done by the Life Vest Technician on 8/2/17 at 12:00 p.m. The facility made the surveyor aware after the fact. DNS and CNC will audit 10% of MD follow up appointment for one week. Then DHS and/or CNC will complete a random audit of doctor's appointment follow up orders weekly for four weeks. This was part of the going forward Plan of Correction. Facility will continue to monitor our performance improvement plan monthly in QAPI meetings. This was part of the going forward Plan of Correction.
F 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to maintain an effective Quality Assurance (QA) program that systematically reviewed quality of care related to services for residents who wore an external defibrillator device. This failure had the potential to affect one resident (R#188) of a sample of 29 residents with a census of 71 residents. The facility failed to ensure they had a policy or procedure in place to address the safe oversight of a resident with an external defibrillator (Life Vest). The failure resulted in no training for the direct care staff in regards to monitoring and/or caring for a resident wearing an external defibrillator device. The deficient practice resulted in an Immediate Jeopardy to the resident's safety, which began on 7/27/17. The Administrator, Nurse Consultant and Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/3/17 at 9:35 a.m. in the area of F328. The Immediate Jeopardy was considered abated as of 2:35 p.m. on 8/3/17, as they had submitted an acceptable plan to remove the IJ related to F328. Cross reference to F328. Findings Include: Life Vest Definition: A Life Vest is a wearable, external defibrillator that is a treatment option for sudden [MEDICAL CONDITION] (SCA) that offers patients advanced protection and monitoring as well as improved quality of life. It is worn outside the body (as opposed to an implantable cardioverter defibrillator (ICD). It continuously monitors the patient's heart with dry, non-adhesive [MEDICATION NAME] to detect life-threatening abnormal heart rhythms. If a life-threatening rhythm was detected, the device alerts the patient prior to delivering a treatment shock, and thus allows a conscious patient to delay the treatment shock. If the patient becomes unconscious, the device releases a Blue gel over the therapy [MEDICATION NAME] and delivers an electric shock to restore normal rhythm. The patient needs to be seen at the Emergency Department, to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115506	A. BUILDING _____ B. WING _____	08/04/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - FAIRBURN	7560 BUTNER ROAD FAIRBURN, GA 30213

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) evaluated by a cardiologist, following a treatment shock and the vest has to be reloaded with new [MEDICATION NAME], as they only release Blue gel once. A subsequent shock without reloading could result in a failed shock and skin burns. On 7/31/17 at 4:55 p.m., review of R#188's clinical record, revealed no documentation either in Progress Notes, Physician order [REDACTED]. An interview with the Director of Nursing (DON) and the facility Nurse Consultant (NC) on 8/2/17 at 10:30 a.m., revealed neither of them were aware R#188 had the Life Vest on. The NC indicated it was facility protocol for anything unusual (like a change in condition, the appearance of unidentified medical equipment, etc.) was to be immediately documented on a form they used entitled Stop and Watch form (A 2-part form where changes regarding the resident was to be noted then passed on to nursing; or documented on the 24-hour Report). They further revealed R#188's Life Vest was never reported in Morning Stand Up meeting. When asked if they had a written policy regarding their protocol to use the Stop and Watch form, the NC stated they did not have one in place and that staff had been told verbally about the use of the form. An interview with the Administrator on 8/2/17 at 3:45 p.m., revealed she was unaware R#188 had a Life Vest on and she was not familiar with its use or required safety and oversight. She also indicated the facility did not have a policy or procedure in place to address the use of external defibrillators. When asked if there would have been any hesitation about accepting a potential resident with an external defibrillator, she stated, no. She further revealed it was the facility protocol for staff to use the Stop and Watch form to document changes in condition, which would include an observation of medical equipment not otherwise noted. They did not have a written policy for the use of the Stop and Watch form. She indicated the facility had monthly Quality Assurance (QA) meetings and provided agendas to document that. There was no evidence they had discussed developing a policy to address external defibrillators and were not aware their procedure for the Stop and Watch program was not working. A telephone interview with the Medical Director (also the Attending Physician) for R#188, on 8/2/17 at 6:15 p.m., revealed he had been the Medical Director of the facility for approximately three years. When asked if he was familiar with the Life Vest, he indicated he was. He further revealed he was not aware R#188 had a Life Vest. He continued to indicate he was familiar with it and was surprised the resident had it applied and had been wearing it for five days without any staff intervention, including him being notified. The Medical Director also indicated he was not aware of any specific policy or procedures the facility had regarding the use of a Life Vest. Continued interview with the Medical Director revealed, when asked, what he would think the facility policy should address regarding the use of a Life Vest, he stated, In general it should allow for training, specifically any special safety instructions and required follow up that may be needed. When the Medical Director was made aware of the fact several staff members were aware R#188 had the Life Vest and had not reported nor documented it, his response was surprise and he stated, That was not what I was told. He further indicated the facility staff had told him no one knew R#188 had the Life Vest until it was identified by the surveyor. A Credible Allegation of Compliance was received on 8/3/17. Based on observations, record reviews, interviews and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated the corrective plans and the immediacy of the deficient practice was removed on 8/3/17. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of resident assessment procedures to ensure any equipment a resident received was physician-ordered; all direct care staff were trained in the proper use/oversight of said medical equipment; and a policy/procedure was instituted to address the use (specifically) of an external defibrillator. This oversight process included the analysis of in-service materials and records on 8/3/17. Interviews were conducted with staff on 8/3/17 to ensure they demonstrated knowledge of facility Policies and Procedures governing external defibrillators. The resident's record was reviewed on 8/3/17 to ensure resident care and treatment, including physician orders [REDACTED]. All verification was confirmed by facility staff interviews, documentation and clincal record reviews. Allegation of Compliance Verification as follows: 1. Immediate Action Taken for Residents: 8/2/2017 at 12:00 p.m. 'Zoll LifeVest Company' did an In-Service for all working staff. In-services continue by the 'Clinical Nurse Consultant (CNC) and the Director of Nursing Services (DNS).' No staff will return to work until in serviced on 'LifeVest' and following up on doctors' orders. 'Zoll LifeVest Company completed assessment of resident R#188 on 8/2/2017. This was verified via interview with the Life Vest Technician on 8/2/17 at approximately 2:30 p.m. Then on 8/2/17 at 4:00 p.m. the Nurse Consultant provided copies of the training outline as well as a list of direct care staff that had obtained training that day. The NC also confirmed no direct care staff would be allowed to work again until they had one to one training from either the NC or DON. A 100% audit was completed 8/2/17 to assure no other residents had an external defibrillator. All residents will be assessed upon admission to facility for external defibrillator. This was verified and confirmed through the interview with the NC on 8/2/17 at 4:00 p.m., all residents residing in the facility were checked for medical devices including any external defibrillator devices and no other resident was identified having such said device. Care Plan was updated 8/2/17 for R#188 to include LifeVest. This was verified and confirmed on 8/2/17 at 4:00 p.m. by review of the actual care plan for R#188. Activities of Daily Living (ADL) care record was updated on 8/2/17 R#188 to reflect LifeVest. This was verified and confirmed 8/2/17 at 4:00 p.m. by review of the actual ADL Care Record for R#188. LifeVest Information pamphlet in Medication Administration Record [REDACTED]. This was verified and confirmed on 8/2/17 by surveyor ensuring these things were in place on the MAR, ADL care record and R#188's closet door. Facility Clinical Start Up form will be used at 9:00 a.m. meeting to ensure follow up of all Medical Doctor (MD) appointments and all MD orders. This future implementation was verified to be put in place by interviews with the facility administration staff members. No form was made available, as it was a part of the Plan of Correction going forward. 2. Action taken to assure no other residents will be affected in the future: An immediate audit of 100% of resident's charts began on 8/2/17 to ensure all MD follow up orders have been implemented. This was verified and confirmed via interview with the NC on 8/2/17 at 4:00 p.m. the Nurse Consultant provided copies of training outline as well as a list of direct care staff that had obtained training that day. The NC also stated no direct care staff would be allowed to work again until they had one to one training from either the NC or DON. The 8/2/17 In-Service on LifeVest to ensure training was given to all direct care staff. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. Training outline to reflect Life Vest care and education was offered and reviewed by the surveyor and found to meet the AOC requirements. In-service staff on proper follow up for all MD appointments. This was verified and confirmed on 8/2/17 at 4:00 p.m. by the NC. 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