STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	084003	A. BUILDING _____ B. WING _____	R-C 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD BEHAVIORAL HEALTH SYSTEM	575 SOUTH DUPONT HIGHWAY NEW CASTLE, DE 19720

(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
{A 144}	Continued From page 12 determined that the facility failed to provide care in a safe setting as evidenced by failure to ensure that all staff members involved in patient care have current active cardiopulmonary resuscitation (CPR) certification; failure to ensure that medications are not left unattended and unsecured in patient care areas; and failure to ensure that patients with orders for one to one (1:1) supervision for safety are receiving 1:1 supervision as ordered. Findings include: 1. Review of facility document "Behavioral Health Associate [BHA] Job Description," dated January 1, 2020, revealed "...Licenses/Designations/Certification: CPR...certification required ..." Review of facility document "RN [Registered Nurse] Job Description," dated January 1, 2020, revealed "...Licenses/Designations/Certifications: CPR...certification required ..." Review of facility document "Incident Log" indicated three active patient deaths occurred in the facility between December 2022 and August 2023. Review of video surveillance from July 22, 2023, between 1:10 AM and 3:40 AM "Code Blue" incident revealed a 9-minute delay between discovery of Patient 5 unconscious and the initiation of CPR by staff. Review of personnel records on August 11, 2023, between 9:05 AM and 12:43 PM, in the presence of EMP10, revealed an email from EMP32 to EMP10 dated August 10, 2023, which stated	{A 144}	**A115 and A144** (CPR Certification) **Findings Summary** The Chief Executive Officer and the Director of Quality were informed the hospital failed to ensure that all staff members involved in patient care have current active cardiopulmonary resuscitation (CPR) certifications **Communication of Findings** MeadowWood Administration notified members of the Governing Board about the findings including failure to ensure that staff members involved in patient care have current active cardiopulmonary resuscitation (CPR) certifications. **The Processes Which Lead to This Deficiency** It was determined that additional education was needed for the Human Resources Staff related to CPR cards always needing to be present in employee files prior to allowing staff to work with patients, as well as education session related to the importance of communicating names of employees who cannot work to the nursing department. It was determined that nurse managers were not regularly receiving updated employee CPR compliance lists. **Process Confirmation and/or Change(s)** The CEO and the Director of Quality reviewed the current MeadowWood staff, specifically those staff responsible for direct patient care. The Human Resources Director will provide a weekly, updated CPR compliance list of employees to the CNO or designee. The CNO or nurse manager designee will cross reference this list against the unit schedules daily to ensure that no staff are scheduled to work with patients who are not CPR trained. The CNO or nurse manager designee will attest daily via signature that all staff scheduled to work with patients have current CPR certification. Human Resources will provide a monthly report on the status of staff responsible for direct patient care, and the overall percentage that have current active cardiopulmonary resuscitation (CPR) certifications. If an employee does not have an active CPR certificate, the employee may not work on the units. Additionally, MeadowWood Administration will ensure that CPR training is accessible to employees. **Completion Date** 12.05.2024	12.05.2024

			Audit and Monitoring Auditing will be done by the Director of Human Resources. Auditing will be completed through reviewing staff responsible for direct patient care, and determining the overall percentage that have current cardiopulmonary resuscitation (CPR) certifications. If an employee does not have an active CPR certificate, the employee may not work on the units. A monthly report will be submitted to the QAPI committee. **Reporting** The Director of Human Resources will provide a monthly Summary Report indicating the overall percentage of direct patient care staff that have active CPR certifications. This Summary Report will be given to the QAPI committee monthly, and to the Governing Board quarterly. **Responsible Person(s)** Director of Human Resources	

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{A 144}	Continued From page 13 "...Attached is a list of individuals that need... [CPR]..." The email included attachments that revealed expired CPR certifications for four RNs and four BHAs. Review of hospital shift schedule documentation provided by EMP 11 indicated that all identified RN and BHA staff with expired CPR certifications have worked since the documented expiration of their CPR certification. 2. Review of facility policy "Medication Order Transcription and Administration," effective October 1991, revised November 2020, revealed "The nurse follows all guidelines of...medication administration...medications are never left unattended outside of medication room..." Review of MR2 "Physician Orders," revealed that Patient 2 was placed on 1:1 (one to one) observation while awake. Review of MR2 "Nurse's Notes," dated August 1, 2023, at 11:07 AM, revealed "Per pt [patient] [he/she] ingested one tan rectangular pill and 1/2 of a round white tablet. Staff attempted to prevent pt from ingesting but pt swallowed medications. Vital signs ordered Q4 [every four hours] x 24 hrs. Pt on 1:1 monitoring. Staff explained risks associated with behavior." Review of surveillance video footage on August 10, 2023, at 10:35 AM in the presence of EMP8 revealed that on August 1, 2023, Patient 2 was able to obtain a pill from the counter while EMP14 was in the room. Review of facility investigation revealed a statement by EMP14 that indicated Patient 2 did	{A 144}	**A115 and A144 (Uncovered 1:1s)** **Findings Summary** The Chief Executive Officer and the Director of Quality were informed the hospital failed to ensure that patients with orders for 1:1 supervision received 1:1 supervision as ordered. **Communication of Findings** MeadowWood Administration notified members of the Governing Board about the findings including uncovered 1:1s. **The Processes Which Lead to This Deficiency** It was determined the uncovered 1:1 was due to a failure to assign 1:1 coverage and supervise that the 1:1 monitoring was maintained. **Process Confirmation and/or Change(s)** The CEO and the CNO/Director of Quality reviewed the Routine Observation of Inpatients policy (see F1 through F5). It was determined that all Registered Nurses, including Nurse Managers and Nursing Supervisors, required re-training regarding staff assignments and supervision related to 1:1s using the Routine Observation of Inpatients policy. The Charge Nurses assign the 1:1 to unit staff member(s) with designating timeframes, document the assignment, communicate assignments to the staff members, and ensure assigned unit duties are executed in a timely and consistent manner In the event there is concern regarding ensuring patient 1:1 coverage, the Charge Nurse notifies the Nursing Coordinator or Nurse Manager. The Nursing Coordinator or Nurse Manager assign 1:1 coverage using in-house resources, and assign staff throughout the hospital to rotate through the 1:1 coverage as needed. The new assignment is communicated to the Charge Nurse and the existing assignment sheet is amended to include the new assignment. The Charge Nurse supervises that the 1:1 is maintained. The Nursing Coordinator and Nurse Manager notify the staffing coordinator of the need for 1:1 coverage for future shifts. Staffing need for 1:1 coverage is reviewed each shift. Continued need for 1:1 is evaluated daily by the treatment team, and this includes consideration of implementing additional interventions to assist the patient in progressing to a less restrictive observation frequency.	12.05.2024

			As a result of the process evaluation, the following was determined: The CNO, in coordination with the nurse managers and the staffing coordinator, will review completed staffing schedules and amend schedules each shift as needed to ensure 1:1 coverage where needed. Nursing supervisors and managers will review and approve staff assignments each shift, ensuring that 1:1's are assigned by the charge RN. **Completion Date** 12.05.2024 **Audit and Monitoring** The Chief Nursing Officer or nurse manager/supervisor designee will monitor each shift that 1:1 coverage is assigned and maintained using the Nursing Supervisor Checklist. **Reporting** The Chief Nursing Officer or Nurse Manager designee will provide a monthly Summary Report to the QAPI committee indicating the overall percentage of 1:1 coverage compliance. This Summary Report will be given to QAPI monthly, and the Governing Board quarterly. **Responsible Person(s)** The Chief Nursing Officer or designee	