STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105592	A. BUILDING _____ B. WING _____	**03/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF VERO BEACH	**1755 37TH STREET VERO BEACH, FL 32960**

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 0578 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on administration and staff interview, policy review, and record review, the facility failed to honor a resident's expressed Advanced Directives, for 1 of 3 sampled residents, Resident #1. The staff failed to follow facility policy and procedure of verifying the resident's code status and initiated CPR on a resident that had a Do Not Resuscitate (DNR) order. There were 137 residents (83 of who had a DNR order) in the facility at the time of survey, all of which could be affected by this failure of verifying code status as per policy. On [DATE], it was determined that the findings of the survey posed immediate jeopardy to the health and safety of the residents residing in the facility. The facility's Administrator was informed of the immediate jeopardy on [DATE] at 12:10 PM. Immediate jeopardy was identified on [DATE], as beginning on [DATE], and removed on [DATE]. The scope and severity were decreased to a D, no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The scope and severity were lowered as a result of the facility's corrective actions implemented as of [DATE] at 3:45 PM. Although the facility implemented multiple corrective actions to remove the immediacy of the deficient practice, the potential for harm remains without the implementation of a plan of correction and the monitoring of corrective action. The findings included: A review of the Policy and Procedure titled Advanced Directives and Code Status, effective [DATE] and revised on [DATE] revealed under the Procedure section Bullet point #8 If a resident is found unresponsive the EHR (Electronic Health Record) must be accessed to determine the code status order. For any resident without a physician's orders [REDACTED]. The Advanced Directive Code Status Quick View Guide further states, the yellow Florida DNR form is for transport communication for EMT's (Emergency Medical Technicians), Medics, and ER (emergency room) staff only. The code status order entered into PCC (Point Click Care - the Electronic medical record software) is the primary source for validating a resident's code status. In the event a resident becomes unresponsive and without pulse or respirations, check the order in PCC. A record review for Resident #1 revealed the resident was admitted to the facility on [DATE] and had a diagnose to include [MEDICAL CONDITION] Disease, anorexia, dysphagia, anxiety, hypertension and [MEDICAL CONDITION]. A State of Florida Do Not Resuscitate Order was signed by the resident's health care surrogate on [DATE] and signed by the resident's physician on [DATE]. A DNR order was in Resident #1's EHR. A nurse's note by Staff A (Registered Nurse/RN), dated [DATE], documented, At 1335 (1:35 PM), resident (#1) was transferred by two CNA's (Certified Nursing Assistants) from her wheelchair to her bed. They made the resident comfortable and then proceeded to the team huddle at the nursing station. Immediately following the huddle, the primary CNA (Staff D) returned to the resident's room and found her unresponsive. CNA called the nurses to the room. This writer (Staff A) ran to the resident's room and checked for pulse and found resident to be pulse-less. Writer then exited the room towards the nursing station to confirm code status. Nursing staff (Staff C, an LPN) at nursing station reported to this writer that the resident was a full code. At 1347 (1:47 PM) CPR initiated, code blue called, and 911 called. 1353 (1:53 PM) Nurse reported resident was not a full code that she was a DNR. CPR continued until 911 arrived at 1355 (1:55 PM). EMT (Emergency Medical Technician) took over code. They pronounced resident's TOD (Time of Death) at 1403 (2:03 PM). Daughter phoned and informed of mother's expiration. Daughter arrived at facility at 1800 (6:00 PM). DCS (Director of Clinical Services) and ED (Executive Director) spoke with daughter concerning mother receiving CPR. Daughter was thankful for the good care that her mother received while in the facility and had no concerns with her receiving CPR. A review of Resident #1's care plans revealed a care plan, initiated on [DATE], stated the resident had an Advanced Directive on record, a health care surrogate (HCS). and a living will, with the DNR dated [DATE]. The care plan stated if resident's heart stop, or resident stops breathing, CPR will not be initiated in honor of the residents DNR wishes. On [DATE] at approximately 11:00 AM, the facility Executive Director and DCS (Director of Clinical Services) agreed the staff failed to correctly verify a resident's code status and performed CPR on a resident who had a DNR order. On [DATE] at 2:00 PM, evidence of clinical nursing staff re-education post event, after [DATE], was requested from the DCS. The DCS responded stating she can do an audit to ensure they have gotten everyone. DCS was not sure all nursing staff have been captured in the drills. The DCS stated they had done 2 drills since the event on [DATE]. An interview was conducted with the DCS on [DATE] at 2:00 PM. During this interview, the DCS stated that the nurse (Staff C, an LPN), who had checked Resident #1's code status, had looked in the paper chart and did not locate a yellow DNR form and assumed the resident was a full code. Staff C did not look in the EMR (electronic medical record) for the code status of the resident. The DCS stated that Staff A was the unit manager and she had checked the EMR system and saw the resident was a DNR. The DCS stated that she went to the resident's room and informed the nurses, but that EMS had already arrived and taken over the code. The DCS further stated that EMS called the resident's death after being informed the resident was a DNR. The DCS stated the yellow DNR form was located later. Subsequent interview with the DCS revealed she completed 1:1 education with the nursing staff involved in the event and gave them a copy of the policy and the nursing staff took a written test. She said that medical records staff had conducted audits on all resident records to ensure correct documentation was in place regarding advanced directives and DNR orders/forms. The DCS further stated the facility had conducted two code blue drills since the event. An interview on [DATE] at 2:25 PM with Staff A revealed the morning of the event Resident #1 was in a wheelchair and in front of the nurse's station for most of the morning. The resident had no concerns that day but did say she had been declining. Staff A (RN) stated that Staff D, (CNA) had put the resident to bed after lunch just prior to a staff huddle at the nurse's station with all the unit staff. After the huddle, Staff D went back to check on the resident and found her unresponsive and asked Staff A for help. Staff A found the resident without a pulse and stated she yelled down the hall for the code status. She had Staff D remove the resident's roommate from the room. Staff C (LPN) replied that Resident #1 was a full code. Staff A went back in the room and started CPR. Other staff called 911 and called a code blue in the facility overhead. After a few minutes of CPR, Staff B,(LPN) came to the room and informed the staff in the resident's room that this resident was a DNR. Staff B had checked the EMR and there was a DNR order and the yellow form was scanned into the EMR system. Staff A stated the person doing CPR at that time had put their hands up, but Staff A informed them that they had to continue CPR until EMS arrived. EMS arrived shortly after and when the EMT's were informed of the resident's code status, they called/pronounced the time of death at 2:03 PM. Staff A further stated she did not look for the order, but that Staff C and B checked the record for the orders. Staff A had stayed with the resident and initiated CPR. Staff A stated she has received additional training since the event, regarding checking for code status and where the information is located. On [DATE] at 10:17 AM, an interview with Staff E (LPN) revealed on the afternoon of the event, she was working on the Seaway unit and heard an overhead page for a code blue to room [ROOM NUMBER]. Staff E stated that she grabbed a backboard and ran to the unit. When

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

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

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F 0578 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Staff E arrived, she asked for the resident's code status. Staff E stated there were about 6 people at the nurse's station shouting she was a full code. When Staff E arrived at the resident's room, CPR was in progress and she began to take notes. After ,[DATE] minutes, 'someone' came in and stated the resident was a DNR. CPR continued until EMS arrived. Once a DNR form was produced to EMS, they stopped CPR and pronounced the resident's death. EMS was shown a scanned copy in the EMR. The yellow form was not in the paper chart. On [DATE] at 10:25 AM, an interview with Staff D (CNA) revealed she was Resident #1's CNA starting in the morning of [DATE]. Staff D stated she felt the resident did not look so well and had informed Staff C (LPN) of her concerns. Staff D stated she informed Staff C that she was going to put the resident back to bed because she had not been looking so good since she arrived in the morning at 7:00 AM. After putting the resident back to bed after lunch, Staff D went back to the resident's room about 15 minutes later and found the resident unresponsive. Staff D has taken care of this resident prior to this date and she was 'total care' resident, but she was responsive and would talk. She stated the resident wasn't herself this day. Staff D stated the CNAs do not verify code status. They do have access to it on PCC, but it is a nursing function to verify code status. CNAs do not 'respond' to a code blue, but the CNAs on the unit will see if the nurses need help to get equipment or remove clutter from rooms. On [DATE] at 11:00 AM, an interview was conducted with the Health Information Specialist (HIS) in reference to the yellow DNR form not being in Resident #1's paper chart. The HIS stated that she had no idea why the yellow form was not in the physical chart. She stated she conducted an audit when she thinned this particular chart in [DATE], and it was there at that time. The HIS checked the information that was thinned from the resident's chart and it was not there either. Post event, the HIS completed a full house audit and Resident #1's chart was the only one that did not have the yellow DNR form, of all the residents who had a DNR order. She stated the form was never found, but that she did print a new form on yellow paper from PCC and placed it in the paper chart. On [DATE] at 11:05 AM an interview was conducted with Staff C (LPN) that revealed Staff C was working the nursing desk on the Independence unit on [DATE]. Staff C stated she saw people go to the room and heard someone say she was a full code. Staff C stated she saw other staff looking in the paper chart and there was no form in the chart, so they stated she was a full code. Staff C stated Staff B checked the computer about five minutes later and saw the resident was a DNR. Staff C stated she was trained to check the paper chart for a yellow form and for some reason her chart did not have the form in place. Staff C stated she has received training since this occurred and they went over code procedure. We now have DNR form in the front of the chart and a doctors order in the chart. Staff C stated that no one reported any concerns about Resident #1 on the date of the event. Staff C has not been part of any code blue drill since the event or prior to the event. Staff C further stated that prior to this event, she was trained on the Seaway unit to look in the paper chart for the yellow form. Staff C stated she has not received code blue, code verification or advanced directive education. Staff C has been provided abuse/neglect training approximately three times in the year that she has been working in the facility. Staff C was not aware of the policy and procedure (P&P) on code blue response. The surveyor read the portion of the advanced directive policy pertaining to verifying code status, and Staff C stated she had never been informed of that, but that she is now aware of the P&P. On [DATE] at 11:25 AM, an interview was conducted with the Medical Director (MD) of the facility. The MD stated that he was informed of the event immediately after it occurred, and that he understands it was a system error and that some staff were not aware of how to locate code status for a resident. He understood the DNR form was not located in the paper chart and that the staff neglected to check the EMR. The MD stated that the DCS has re-educated staff on how to verify code status. The MD feels there should be no delay in starting CPR on a resident who is found unresponsive. He feels time is wasted looking for code status and there should not be a delay. The MD would like to see a system put into place, such as a symbol above the resident's bed or in the room to let staff know what the code status is for a resident. The MD stated staff should have stopped CPR once they found out the resident was a DNR and that he felt that was an error. The MD feels that the resident was deceased and not able to feel pain, so he does not believe the staff harmed the resident by doing CPR. On [DATE] at 11:40 AM, an interview conducted with Staff F (LPN) revealed the facility has provided her with code response training. Staff F stated she did participate in a code blue drill but was unsure how long ago that was. Staff F stated to verify code status she would check PCC for an order and writes it on her daily assignment sheet, so she is aware of who is a full code and who is a DNR. On [DATE] at 1030 AM, an interview with Staff G (LPN) revealed training was provided by the facility last week regarding verifying code status. Staff G has not participated in a code blue drill since the event occurred. Staff G has received abuse/neglect training. On [DATE] at 10:40 AM, an interview was conducted with Staff H, a clinical support specialist, that revealed her role is to remain at the desk and make calls as needed. Staff H did confirm additional training regarding code status and code blue response. Staff H has received abuse/neglect training from the facility. On [DATE] at 10:43 AM, an interview was conducted with Staff I, an agency LPN. Staff I stated that this was his first day in this facility and that he was aware to look for the code status of a resident in the electronic record. Staff I stated that he also writes down all the residents code status that he is assigned to. On [DATE] at 12:10 PM, the DCS and ED were informed of Immediate Jeopardy, and a Removal Plan was requested. The facility provided a Removal Plan on [DATE] at 4:05 PM, that was not acceptable and required revision to include review of the facility's policies to all staff. The ED provided a revised Removal Plan on [DATE] at 12:30 PM. On [DATE] at 2:00 PM and on ,[DATE] at 10:00 AM, the surveyor had requested documentation or evidence of training to the nursing staff, related to staff knowing the P&P related to the location of the DNR status for residents who were DNR. The DCS said she would need to complete an audit to determine the number of nurses who had received education. The documentation was not provided until [DATE] at 11:00 AM. On [DATE] at approximately 2:00 PM, the sign in sheets for code blue drills for the past 6 months were presented to the surveyor. The DCS informed surveyor that a drill was done 'last night'. This information was not included in the sign in sheets given to the surveyor at this time. One drill was dated post event on [DATE] at 2:00 PM. A mock drill code sheet was not included with the sign in sheet and the sign in sheet had signatures of only CNA's, and no nurses. The sign in sheets for licensed nurses were lacking. This had been requested along with the code blue drill completed on [DATE] at 7:58 PM per DCS. The facility's Immediate Jeopardy revised Removal Plan, dated [DATE], but provided to the surveyor on [DATE] at 12:30 PM, included the following: Resident #1 was the only resident affected by the deficient practice and had expired. The resident's daughter was contacted at 2:15 PM to inform her of the resident expiration. The daughter was updated on the events at approximately 6:00 PM. Immediate education on Advanced Directives - Code Status was initiated by the DCS with all licensed staff. The education consisted of one on one review of the Advanced Directive Code Status Policy, the Advanced Directive Quick View Guide, as well as Code Documentation form. The education was initiated on [DATE] with all licensed nursing staff and completed on [DATE]. Details of the code were reviewed with the Medical Director on [DATE]. The HIS initiated weekly code status audits on [DATE] consisting of a review of the DNR order and the DNR form in the physical record and on PCC EMR. The audits are reviewed by the DCS. Code blue drill completed by DCS/designee on [DATE] at 2:00 PM with nursing staff. Post review of the drill consisted of code called via intercom, code status identified, 911 called, crash cart obtained, airway assessed (Mock Code Checklist attached for full details). A Code Blue Drill was completed on [DATE] at 7:58 PM with nursing staff. (Mock Code Checklist attached for details). The P&P for Resident Rights were reviewed. Staff were educated on Resident Rights on [DATE]. All newly hired licensed nurses will be educated on Advanced Directive Code Status Policy, the Advanced Directive Quick Guide, the Code Documentation form and Resident Rights prior to floor orientation. Random audits of Resident Rights will be continued by department managers for compliance. The DCS will bring results of random audits to QAPI meeting monthly for 3 months, then quarterly for 3 quarters. The plan will be revised as needed. On [DATE] at approximately 11:00 AM, the RN and LPN education was provided to the surveyor. At this time, 100% of RN's and LPN were documented as completing the education either in person or via telephone and it was dated ,[DATE], 14, and ,[DATE]. The mock code blue drill forms were requested again. On [DATE], the information in the facility's removal plan was verified. Staff members were interviewed to confirm the implementation of the facility's removal plan and included 2 RN's, 12 LPN's, 4 CNA's, and 1 Clinical Support Specialist. All staff member voiced that they did receive education post event on code blue response. The licensed nurses, except for one (See Staff C interview above) voiced the code status of a resident is to be verified by looking into the electronic health record (PCC). Approximately 20 random charts were reviewed and there were no discrepancies identified in reference to code status for all residents reviewed. The Code Blue drills included 17 of 46 nurses who participated in the drills. The sign-in sheets for education included 100% of nurses, including RNs and LPNs. Interviews to verify the removal plan included: On [DATE] at 10:17 AM, Staff E stated that training was received immediately that day on code status, and a chart audit was completed for the entire facility. Staff E stated that she has not participated in a code blue drill since this event as of the date of this interview. She further stated code blue drills are done every few months. Staff E confirmed she had education on advanced directives and abuse/neglect training. Staff E verified the correct process to verify code

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F 0578 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) status was to check PCC (point click care - electronic record system). On [DATE] at 10:47 AM, an interview was conducted with Staff J, an LPN, who was a contract employee. Staff J stated that she was given copies of the abuse/neglect policy and the advanced directive P&P prior to starting on the floor at this facility. Staff J stated she would look for a residents' code status in the electronic medical record and she also took it upon herself to write down all her resident's code status on her daily assignment sheet. On [DATE] at 12:42 PM, a phone interview was conducted with Staff L, an RN, that revealed she was aware of the Advanced Directive/Code P&P. She stated they were to check the electronic record for code status. Staff L further stated that she has received training over the past week for advanced directives and how to verify code status of a resident. Staff L has been trained on the abuse/neglect P&P. On [DATE] at 1:10 PM, a phone interview with Staff K, an LPN, revealed she was aware to check for code status in the electronic health record and has been re-educated on the advanced directive P&P within the past week. Staff K stated she has received training on abuse/neglect from the facility. On [DATE] at 1:20 PM, a phone interview with Staff M, an LPN, revealed she was aware to check for code status in the electronic health record and has been re-educated on the advanced directive P&P within the past week. Staff M stated she has received training on abuse/neglect from the facility. On [DATE] at 1:23 PM, a phone interview with Staff O, an LPN, revealed she was aware to check for code status in the electronic health record and has been re-educated on the advanced directive P&P within the past week. Staff O stated she has received training on abuse/neglect from the facility. On [DATE] at 1:25 PM, a phone interview with Staff N, an LPN, revealed she was aware to check for code status in the electronic health record and has been re-educated on the advanced directive P&P within the past week. Staff N stated she has received training on abuse/neglect from the facility. On [DATE] at 3:05 PM, an interview with Staff P, an CNA, revealed she received training on code blue response and participated in a code blue drill recently. Staff P stated in a code situation she would grab the crash cart and see what else was needed. If nothing was needed at the time, she would stay near in case any assistance was needed. On [DATE] at 3:08 PM an interview with Staff Q, a CNA, revealed she had received additional education on code blue response. If a code blue was called, she would respond by going to the area of the code to see if assistance was needed. She stated she participated in a code blue drill about a week ago. On [DATE] at 3:10 PM, an interview with Staff R, a CNA and Staffing Coordinator, revealed she had participated in a code blue drill during the past two weeks but was unsure of the date. Staff Q stated additional code blue education was done by the facility last week. When she responds to a code blue, she reports to the area and awaits instructions. It is the nurse's responsibility to check code status. On [DATE] at approximately 11:00 AM, the mock code blue drill forms were presented to the surveyor for [DATE] and [DATE] along with sign in sheets for the licensed nursing staff. At this time, 17 of 46 licensed nursing staff have participated in code blue drills as of exit on [DATE]. A review of the sign in sheet dated [DATE] contains Staff C's name and signature. The interview conducted on [DATE] at 11:05 AM with Staff C revealed she had not participated in any code blue drills since [DATE]. The facility's immediate jeopardy was removed on [DATE] at 3:45 PM.
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, policy review and record review, the facility staff neglected to follow facility policy and procedure of verifying the resident's code status and performed CPR on a resident that was a Do Not Resuscitate (DNR). The facility neglected to ensure the Advanced Directives were followed as per the resident's wishes, for 1 of 3 sampled residents, Resident #1. This medical neglect potentially harmed or caused the resident undue pain during cardiopulmonary resuscitation. There were 137 residents, 83 of who had a DNR order, in the facility at the time of survey, all of which could be affected by this medical neglect. On [DATE], it was determined that the findings of the survey posed immediate jeopardy to the health and safety of the residents residing in the facility. The facility's Administrator was informed of the immediate jeopardy on [DATE] at 12:10 PM. The immediate jeopardy was identified on [DATE], as beginning on [DATE] and removed on [DATE] at 3:45 PM. The scope and severity were decreased to a D, no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The scope and severity were lowered as a result of the facility's corrective actions completed as of [DATE]. Although the facility implemented multiple corrective actions to remove the immediacy of the deficient practice, the potential for harm remains without the implementation of a plan of correction and the monitoring of corrective action. The findings included: A review of the facility policy titled Abuse Prohibition Policy and Procedure effective [DATE] and revised [DATE] revealed: Neglect means the Failure of the center, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This policy further states that All employees have a duty to respect the rights of all resident's, to treat them with dignity and to prevent others from violating the resident's rights. A review of the Policy and Procedure titled Advanced Directives and Code Status, effective [DATE] and revised on [DATE] revealed under the Procedure section Bullet point #8 If a resident is found unresponsive the EHR (Electronic Health Record) must be accessed to determine the code status order. For any resident without a physician's order for DNR (Do Not Resuscitate), or without documented wishes to withhold CPR (Cardiopulmonary Resuscitation), EMS (Emergency Medical Services)/911 must be called, the attending physician notified, and emergency basic life support (CPR) must begin. The Advanced Directive Code Status Quick View Guide further states, the yellow Florida DNR form is for transport communication for EMT's (Emergency Medical Technicians), Medics, and ER (emergency room) staff only. The code status order entered into PCC (Point Click Care - the Electronic medical record software) is the primary source for validating a resident's code status. In the event a resident becomes unresponsive and without pulse or respirations, check the order in PCC. A record review for Resident #1 revealed the resident was admitted to the facility on [DATE]. A State of Florida Do Not Resuscitate Order was signed by the resident's health care surrogate on [DATE] and signed by the resident's physician on [DATE]. A DNR order was in Resident #1's EHR. A nurse's note by Staff A (Registered Nurse/RN), dated [DATE], documented, At 1335 (1:35 PM), resident (#1) was transferred by two CNA's (Certified Nursing Assistants) from her wheelchair to her bed. They made the resident comfortable and then proceeded to the team huddle at the nursing station. Immediately following the huddle, the primary CNA (Staff D) returned to the resident's room and found her unresponsive. CNA called the nurses to the room. This writer (Staff A) ran to the resident's room and checked for pulse and found resident to be pulse-less. Writer then exited the room towards the nursing station to confirm code status. Nursing staff (Staff C, an LPN) at nursing station reported to this writer that the resident was a full code. At 1347 (1:47 PM) CPR initiated, code blue called, and 911 called. 1353 (1:53 PM) Nurse reported resident was not a full code that she was a DNR. CPR continued until 911 arrived at 1355 (1:55 PM). EMT (Emergency Medical Technician) took over code. They pronounced resident's TOD (Time of Death) at 1403 (2:03 PM). Daughter phoned and informed of mother's expiration. Daughter arrived at facility at 1800 (6:00 PM). DCS (Director of Clinical Services) and ED (Executive Director) spoke with daughter concerning mother receiving CPR. Daughter was thankful for the good care that her mother received while in the facility and had no concerns with her receiving CPR. A review of Resident #1's care plans revealed a care plan, initiated on [DATE], stating the resident has an Advanced Directive on record, a health care surrogate (HCS). and a living will, with the DNR dated [DATE]. The care plan stated if resident's heart stop, or resident stops breathing, CPR will not be initiated in honor of the residents DNR wishes. On [DATE] at approximately 11:00 AM, the facility Executive Director and DCS (Director of Clinical Services) agreed the staff failed to correctly verify a resident's code status and performed CPR on a resident who had a DNR order. On [DATE] at 2:00 PM, evidence of clinical nursing staff training was requested from the DCS. The DCS responded stating she can do an audit to ensure they have gotten everyone. The DCS was not sure that all nursing staff have been captured in the drills. The DCS stated they had done 2 drills since the event on [DATE]. An interview was conducted with the DCS on [DATE] at 2:00 PM. During this interview, the DCS stated that the nurse (Staff C, LPN) who checked Resident #1's code status had looked in the paper chart and did not locate a yellow DNR form and assumed the resident was a full code. Staff C did not look in the EMR (electronic medical record) for the code status of the resident. The DCS further stated that Staff A was the unit manager and she checked the EMR system and saw the resident was a DNR. The DCS stated that she went to the resident's room and informed the nurses, but that EMS had already arrived and taken over the code. The DCS further stated that EMS called / pronounced the resident's death after being informed the resident was a DNR. The DCS stated the yellow DNR form was located later. An interview on [DATE] at 2:25 PM with Staff A (RN) revealed the morning of the event Resident #1 was in a wheelchair and in front of the nurse's station for most of the morning. The resident had no concerns that day but did say she had been declining. Staff A stated the Staff D (CNA) had put the resident to bed after lunch just prior to a staff huddle at the nurse's station with

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) all the unit staff. After the huddle, Staff D went back to check on the resident and found her unresponsive and asked Staff A for help. Staff A found the resident without a pulse and stated she yelled down the hall for the code status. She had Staff D remove the resident's roommate from the room. Staff C replied that Resident #1 was a full code. Staff A went back in the room and started CPR. Other staff called 911 and called a code blue in the facility overhead. After 'a few minutes' of CPR Staff B (LPN) came to the room and informed the staff in the resident's room that this resident was a DNR. Staff B had checked the EMR and there was a DNR order and the yellow form was scanned into the EMR system. Staff A stated the person doing CPR at that time put their hands up, but Staff A informed them that they had to continue CPR until EMS arrives. EMS arrived shortly after and when the EMT's were informed of the resident's code status, the celled the time of death at 2:03 PM. Staff A stated she did not look for the order and that Staff C and B checked the record for the orders. Staff A stayed with the resident and initiated CPR. On [DATE] at 10:17 AM, an interview with Staff E (LPN) revealed on the afternoon of the event, she was working on the Seaway unit and heard an overhead page for a code blue to room [ROOM NUMBER]. Staff E stated she grabbed a backboard and ran to the unit. When Staff E arrived, she asked for the resident's code status. Staff E stated there was about 6 people at the nurse's station shouting she was a full code. When Staff E arrived at the resident's room, CPR was in progress and she began to take notes. After ,[DATE] minutes, 'someone' came in and stated the resident was a DNR. CPR continued until EMS arrived. Once the DNR form was provided to EMS they stopped CPR and pronounced the resident's death. EMS was shown a scanned copy in the EMR. The yellow form was not in the paper chart. On [DATE] at 10:25 AM, an interview with Staff D (CNA) revealed she was Resident #1's CNA starting in the morning of [DATE]. Staff D stated she felt the resident did not look so well, and had informed Staff C (LPN) of her concerns. Staff D stated she informed Staff C that she was going to put the resident back to bed because she has not been looking so good since she arrived in the morning at 7:00 AM. After putting the resident back to bed after lunch, Staff D went back to the resident's room about 15 minutes later and found the resident unresponsive. Staff D has taken care of this resident prior to this date and she required total care, but she was responsive and would talk. She stated she wasn't herself this day. Staff D stated CNA's do not verify code status. They do have access to it on PCC, but it is a nursing function to verify code status. She said CNAs do not respond to a code blue, but the CNAs on the unit will see if they need help to get equipment or remove clutter from rooms. Staff D is CPR certified and said she does receive abuse/neglect training often. On [DATE] at 11:00 AM, an interview was conducted with the Health Information Specialist (HIS) in reference to the yellow DNR form for not being in Resident #1's paper chart. The HIS stated that she had no idea why the yellow form was not in the physical chart. She stated she conducted an audit when she thinned this chart in [DATE], and it was there at that time. The HIS checked the information that was thinned from the resident's chart and it was not there either. On [DATE] at 11:05 AM, an interview conducted with Staff C (LPN) revealed that Staff C was working the nursing desk on the Independence unit on [DATE]. Staff C stated she saw people go to the room and heard someone say she was a full code. Staff C stated she saw other staff looking in the paper chart and there was no form in the chart, so they stated she was a full code. Staff C stated Staff B checked the computer about five minutes later; and saw the resident was a DNR. Staff C further stated that no one reported and concerns about Resident #1 on the date of the event. Staff C had not been part of any code blue drill since the event or prior to the event. Staff C further stated that prior to this event, she was trained on the Seaway unit to look in the paper chart for the yellow form. Staff C stated she has not received code blue, code verification or advanced directive education. Staff C has been provided abuse/neglect training approximately three times in the year she has been working in the facility. Staff C was not aware of the policy and procedure (P&P) on code blue response. The surveyor read the portion of the advanced directive policy pertaining to verifying code status, and Staff C stated she had never been informed of that, but that she is now aware of the P&P. On [DATE] at 11:25 AM, an interview was conducted with the Medical Director (MD) of the facility. The MD stated that he was informed of the event immediately after it occurred, and that he understands it was a system error and that some staff were not aware of how to locate code status for a resident. He understood the DNR form was not located in the paper chart and that the staff neglected to check the EMR. The MD stated that the DCS has re-educated staff on how to verify code status. The MD feels there should be no delay in starting CPR on a resident who is found unresponsive. He feels time is wasted looking for code status and there should not be a delay. The MD would like to see a system put into place, such as a symbol above the resident's bed or in the room to let staff know what the code status is for a resident. The MD stated staff should have stopped CPR once they found out the resident was a DNR and that he felt that was an error. The MD feels that the resident was deceased and not able to feel pain, so he does not believe the staff harmed the resident by doing CPR. On [DATE] at 12:10 PM, the DCS and ED were informed of Immediate Jeopardy, and a Removal Plan was requested. The facility provided a Removal Plan on [DATE] at 4:05 PM, that was not acceptable and required revision to include review of the facility's policies to all staff. The ED provided a revised Removal Plan on [DATE] at 12:30 PM. On [DATE] at 2:00 PM and on ,[DATE] at 10:00 AM, the surveyor had requested documentation or evidence of training to the nursing staff, related to staff knowing the P&P related to the location of the DNR status for residents who were DNR. The DCS said she would need to complete an audit to determine the number of nurses who had received education. The documentation was not provided until [DATE] at 11:10 AM. On [DATE] at approximately 2:00 PM, the sign in sheets for code blue drills for the past 6 months were presented to the surveyor. The DCS informed surveyor that a drill was done 'last night'. This information was not included in the sign in sheets given to the surveyor at this time. One drill was dated post event on [DATE] at 2:00 PM. A mock drill code sheet was not included with the sign in sheet and the sign in sheet had signatures of only CNA's, and no nurses. The sign in sheets for licensed nurses were lacking. This had been requested along with the code blue drill completed on [DATE] at 7:58 PM per DCS. The facility's Immediate Jeopardy revised Removal Plan, dated [DATE], but provided to the surveyor on [DATE] at 12:30 PM, included the following: Resident #1 was the only resident affected by the deficient practice and has expired. The resident's daughter was contacted at 2:15 PM to inform her of the resident expiration. The daughter was updated on the events at approximately 6:00 PM. Details of the code were reviewed with the Medical Director on [DATE]. The Health Information Manager initiated weekly code status audits on [DATE], consisting of a review of the DNR order and the DNR form in the physical record and on PCC EMR. The audits are reviewed by the DCS. Code blue drill completed by DCS/designee on [DATE] at 2:00 PM with nursing staff. Post review of the drill consisted of code called via intercom, code status identified, 911 called, crash cart obtained, airway assessed. A Code Blue Drill was completed on [DATE] at 7:58 PM with nursing staff. An interview on [DATE] at approximately 2:15 PM, with the DCS revealed she completed 1:1 education with the nursing staff involved in the event and gave then a copy of the policy and the nursing staff took a written test. Immediate education on Advanced Directives - Code Status was initiated by the DCS with all licensed nursing staff. The education consisted of one on one review of the Advanced Directive Code Status Policy, the Advanced Directive Quick View Guide, as well as Code Documentation form. The education was initiated on [DATE] with all licensed nursing staff and completed on [DATE]. On [DATE] at 2:25 PM, an interview with Staff A revealed she had received additional training since the event regarding checking for code status and where the information is located. Staff A is CPR certified. Staff A stated the facility has provided her with multiple training on abuse and neglect. In an interview on [DATE] at 10:17 AM, Staff E stated that training was received immediately that day on code status, and a chart audit was completed for the entire facility. In this interview on [DATE] at 10:17 AM, Staff E stated that she has not participated in a code blue drill since this event, as of the date of this interview. She further stated code blue drills are done every few months. Staff E confirmed she had education on advanced directives and abuse/neglect training. Staff E verified the correct was top verify code status is to check PCC. An interview with the HIS on [DATE] at 11:00 AM, revealed post event, the HIS completed a full house audit and that was the only chart that did not have the yellow DNR form, of those who had a DNR order. She stated the form was never found, but that she did print a new form on yellow paper from PCC and placed it in the paper chart. In an interview on [DATE] at 11:05 AM, Staff C stated she was trained to check the paper chart for a yellow form and for some reason Resident #1's chart did not have the form in place. Staff C stated she has received training since this occurred and they went over code procedure. We now have DNR form in the front of the chart and a doctors order in the chart. On [DATE] at 11:40 AM, an interview conducted with Staff F (LPN) revealed the facility had provided her with abuse/neglect training often and has received code response training. Staff F stated she did participate in a code blue drill but was unsure how long ago that was. Staff F stated to verify code status, she would check PCC for an order and write it on her daily assignment sheet, so she is aware of who is a full code and who is a DNR. On [DATE] at 1030 AM, an interview with Staff G (LPN) revealed training was provided by the facility last week regarding verifying code status. Staff G has not participated in a code blue drill since the event occurred. Stagg G has received abuse/neglect training. On [DATE] at 10:40 AM, an interview was conducted with Staff H, a clinical support specialist, who revealed her role is to remain at the desk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105592	A. BUILDING _____ B. WING _____	03/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF VERO BEACH	1755 37TH STREET VERO BEACH, FL 32960

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) and make calls as needed. Staff H did confirm additional training regarding code status and code blue response. Staff H has received abuse/neglect training from the facility. On [DATE] at 10:47 AM, an interview was conducted with Staff J (LPN), who is a contract employee. Staff J stated that she was given copies of the abuse/neglect policy and the advanced directive P&P prior to starting on the floor at this facility. Staff J stated she would look for a resident's code status in the electronic medical record and she also took it upon herself to write down all her resident's code status on her daily assignment sheet. On [DATE] at 12:42 PM, a phone interview was conducted with Staff L (RN), who revealed she was aware of the Advanced Directive/Code P&P. She stated they were to check the electronic record for code status. Staff L further stated that she has received training over the past week for advanced directives and how to verify code status of a resident. Staff L has been trained on the abuse/neglect P&P. On [DATE] at 1:10 PM, a phone interview with Staff K (LPN) revealed she was aware to check for code status in the electronic health record and has been re-educated on the advanced directive P&P within the past week. Staff K stated she has received training on abuse/neglect from the facility. On [DATE] at 1:20 PM, a phone interview with Staff M (LPN) revealed she was aware to check for code status in the electronic health record and has been re-educated on the advanced directive P&P within the past week. Staff M stated she has received training on abuse/neglect from the facility. On [DATE] at 1:23 PM, a phone interview with Staff O (LPN) revealed she was aware to check for code status in the electronic health record and has been re-educated on the advanced directive P&P within the past week. Staff O stated she has received training on abuse/neglect from the facility. On [DATE] at 1:25 PM, a phone interview with Staff N (LPN) revealed she was aware to check for code status in the electronic health record and has been re-educated on the advanced directive P&P within the past week. Staff N stated she has received training on abuse/neglect from the facility. On [DATE] at 3:05 PM, an interview with Staff P (CNA) revealed she received training on code blue response and participated in a code blue drill recently. Staff P stated in a code situation, she would grab the crash cart and see what else was needed. If nothing was needed at the time, she would stay near in case any assistance was needed. Staff P stated she has received abuse/neglect training recently. On [DATE] at 3:08 PM, an interview with Staff Q (CNA) revealed she had received additional education on code blue response. If a code blue was called, she would respond by going to the area of the code to see if assistance was needed. She stated she participated in a code blue drill about a week ago. Staff Q stated she has received abuse/neglect training from the facility. On [DATE] at 3:10 PM, an interview with Staff R (CNA and Staffing Coordinator) revealed she had participated in a code blue drill during the past two weeks but was unsure of the date. Staff Q stated additional code blue education was done by the facility last week. When she responds to a code blue, she reports to the area and awaits instructions. She said it is the nurse's responsibility to check code status. Staff R stated she has received abuse/neglect training from the facility. A review of the facility education revealed several Abuse/Neglect in-services over the past year. All newly hired licensed nurses will be educated on Advanced Directive Code Status Policy, the Advanced Directive Quick Guide, the Code Documentation form and Resident Rights prior to floor orientation. Monthly code blue drills on each shift will be conducted by the DCS/designee for compliance. The DCS will bring results of random audits to QAPI meeting monthly for 3 months, then quarterly for 3 quarters. The plan will be revised as needed. On [DATE], the prior (,[DATE] and [DATE]) requested sign-in sheets were provided at approximately 11:00 AM. On [DATE], the information in the facility's removal plan was verified. Staff members were interviewed (see interviews above) to confirm the implementation of the facility's removal plan and included 2 RN's, 11 LPN's, 4 CNA's, and 1 Clinical Support Specialist. All staff member voiced that they did receive education post event on code blue response. The licensed nurses, except for one (See Staff C interview above) voiced the code status of a resident is to be verified by looking into the electronic health record (PCC). The Code Blue drills included 17 of 46 nurses who participated in the drills. Approximately 20 random charts were reviewed and there were no discrepancies identified in reference to code status for all residents reviewed. On [DATE] at approximately 11:00 AM, the sign-in sheets / forms were presented to the surveyor for the ,[DATE]-,[DATE] trainings for the licensed nursing staff. At this time, a 100 % of nursing staff had received training and education. The facility's immediate jeopardy was removed on [DATE] at 3:45 PM.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility documentation, the facility failed to ensure an alleged violation of neglect with serious injury was reported within two hours as per the regulation, effecting 1 of 3 sampled residents reviewed (Resident #1). The findings included: A review of the medical record for Resident #1 revealed the resident received Cardiopulmonary Resuscitation (CPR) at 1:47 PM on [DATE]. The medical record revealed this resident had advanced directives and an order for [REDACTED]. This is over four hours post event. An interview with the Director of Clinical Services (DCS) on [DATE] at 10:00 AM, revealed she was unsure why the reporting was delayed. An interview with the Assistant Executive Director (AED), on [DATE] at 10:40 AM, revealed she is the person responsible for reporting to the state. She stated that she did not hear the code blue called overhead on [DATE] and was not informed of the event until after 3:00 PM. The AED began to get statements from the staff, but since it was shift change it was difficult to do timely. The AED contacted the Department of Children and Families (DCF) and called law enforcement (LE). She stated she waited a while, waiting for LE to show up to the facility, since this is required for the immediate report. DCF did not accept the case and shortly after 6:00 PM, she went ahead with completing the immediate report without LE reporting. The AED stated she is aware of the two hour reporting requirement, but was trying to get as much information as she could for the report. She said that since she was not informed of the event until an hour and a half had already passed, she knew it was going to over the two hours. On [DATE] at approximately 10:00 AM, the DCS (Directof of Clinical Services) was made aware of the delayed reporting. No further information was given to the surveyor in reference to the reason for the delay in alerting the AED of a reportable event.