STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105888	A. BUILDING _____ B. WING _____	**04/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLANTATION BAY REHABILITATION CENTER	**4641 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34769**

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 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to honor a resident's advance directives and did not follow physician's order to provide basic life support and initiate Cardiopulmonary Resuscitation (CPR) for 1 of 3 sampled residents, (#1) in a total sample of 8 residents reviewed for code status. Resident #1 had advance directives and physician's order that did not include withholding of cardiopulmonary resuscitation (CPR). On [DATE], at approximately 7:10 AM, resident #1 was found unresponsive in bed with absence of vital signs. Two facility nurses, Licensed Practical Nurse, (LPN) B & Registered Nurse (RN) A failed to verify the resident's code status which included Cardiopulmonary Resuscitation to be initiated. They did not initiate CPR as per the resident's wishes or call 911 per facility policy after finding the resident unresponsive. The resident died . The facility's failure to provide CPR per the resident's advance directives, and physician orders, resulted in Isolated Immediate Jeopardy beginning on [DATE]. The Immediate Jeopardy was determined to be Past Noncompliance. The facility administrator was notified of the Immediate Jeopardy on [DATE] at 3:45 PM. The Immediate Jeopardy was removed on [DATE]. The facility's non-compliance was corrected on [DATE] when the facility had fully implemented corrective actions. Findings: Resident #1 was a long-term care resident and had been initially admitted to the facility on [DATE] for non-Alzheimer's dementia, [MEDICAL CONDITION], and [MEDICAL CONDITIONS]. On [DATE], resident #1 was hospitalized and returned to the facility on [DATE]. His readmission [DIAGNOSES REDACTED]. On [DATE], he was again hospitalized and returned to the facility on [DATE]. The readmission [DIAGNOSES REDACTED]. The facility's policies and procedure for Cardiopulmonary Resuscitation, dated [DATE], included the following: Cardiopulmonary Resuscitation will be provided to all residents who are identified to be in [MEDICAL CONDITION] unless such resident has a fully executed Do Not Resuscitate order (DNRO) order. The procedure included, In the event of [MEDICAL CONDITION], immediately call for assistance . Two licensed nurses are to verify resident identification and fully executed Do Not Resuscitate order . Use the paging system and call Code Blue to Room Number or location of the event three times. .In the absence of a fully executed Do Not Resuscitate order the facility will immediately begin CPR. Center staff will continue performing CPR until Emergency Medical Technicians assume responsibility for CPR, or it may be discontinued if: the resident responds . Notify the physician and resident representative/legal representative . Document in the medical record. Resident #1's physician orders revealed that he had been a full code status since his admission on [DATE]. The most recent full code status order was dated [DATE]. The full code status order was continued at that time. LPN B's progress note dated [DATE] at 12:43 PM read, Resident found in room absent of breath, pulse, Dr (Doctor) . and family notified . funeral home here at 11:05 AM to receive the body. There was no documented evidence that a Code Blue had been called when the resident was found unresponsive. There was no documented evidence that CPR had been initiated or that 911 had been called. On [DATE] at 1:12 PM, Certified Nursing Assistant (CNA) C said that she was resident #1's assigned CNA on the 7 AM-3 PM shift on the day he died , [DATE]. She stated that when she entered resident 1's room on [DATE] at approximately 7:10 AM, she noted that he did not look right. I looked at him . his eyes were wide open and his mouth was open. She said he did not respond to her verbal stimulus and when she touched him, he was still warm. CNA C said that she called out to CNA D, who was coming out from the room across the hallway, to come into the room and help her check the resident. CNA C said that she checked for a pulse on his wrist and CNA D checked for a pulse on his neck, but that neither could find one. She said they immediately went to the door and called out for help from Registered Nurse (RN) A in the hallway. RN A came into the room first and then resident #1's assigned nurse, LPN B, was seen coming down the hallway. RN A told LPN B to disconnect the feeding machine and the oxygen, and told her to go check the chart. CNA C said RN A then told the CNAs to clean up the resident. She said LPN B, who was new to the facility, had asked RN A for help in what to do. According to CNA C, RN A had responded by saying You've been a nurse long enough, you should know what to do. CNA C said that she was not aware at that time whether the resident was a full code or DNR. She said that she did not actually see if the nurses checked the resident's medical record. She said she noted there was no Code Blue paged on the overhead speaker and no CPR initiated for resident #1. A telephone interview was conducted on [DATE] at 5:22 PM with CNA D. She said that it was just shortly after 7 AM when CNA C called her into resident #1's room. She said the resident was unresponsive and they checked for pulses. She said that he was warm to touch, but had no vital signs. They called the nurses to come into the room. She said that no Code Blue was called and no CPR was given. She was asked by RN A and LPN B to help CNA C clean up the resident. CNA D said that she found out at the end of her shift on [DATE] about the resident's code status and that CPR should have been started. She could not explain why resident #1 did not receive CPR. She said, The CNAs were looking toward the nurse for direction and the nurses acted like he was a DNR. She said she thought the nurses had checked his code status, . and they did not instruct anyone to do CPR. She stated, They (the nurses) were superiors and we were looking to them for instruction. The facility's Advanced Directive policy and procedure, revised [DATE], included the following: The center will abide by state and federal laws regarding advance directives. The center will honor all properly executed advance directives that have been provided by the resident and/or resident representative . Social Services and/or Business Development Coordinator/designee will assist the resident/resident representative to complete the Advance Directives Discussion Document. If an advance directive exists the Social Services . designee will obtain a copy and place it in the resident's medical record . Advanced Directives will be reviewed: Quarterly, Hospice Admission, and additional times as need or requested by the resident/resident representative On [DATE] at 12:04 PM, the Social Services Director (SSD) said that she was the manager on duty (MOD) on Sunday [DATE]. She said she arrived at the facility at 8:30 AM. At 9 AM she was rounding on the North Wing where resident #1 resided. She saw that resident #1's daughter was crying in the hallway. She said the daughter informed her that her father had passed away earlier in morning. The SSD stated that she verified with LPN B that the resident had passed. She then reviewed resident #1's medical record at about 3:00 PM. She read the nurse's note and saw no documentation that a Code Blue had been called or that CPR had been initiated. She reviewed the Advanced Directives tab in the paper copy chart and found that his Advance Directives Discussion Document, dated [DATE], indicated he was a full code indicating that CPR should have been initiated. The SSD said she immediately spoke to LPN B and asked her if CPR had been performed. She said LPN B was surprised and stated, He was a full code? The SSD said that LPN B reported to her that she had not looked in the medical record for the code status as he was already deceased when she entered his room. The SSD added that when she asked LPN B if she had checked his code status, LPN B reported to her, . I didn't think to check on that (code status) because he was already gone. The SSD said that she quickly reported this to the director of clinical services (DCS) who immediately came to the facility and started an investigation. At this time, review of resident #1's medical record with the SSD validated that resident #1 was a full code. She also validated that resident #1's Advance Directives Discussion forms, dated [DATE] indicated the resident and resident representative's wishes were for full code and CPR to be provided. The SSD said

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 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) resident #1's daughter was his health care proxy and was very involved with her father's care. She visited him daily. She said the daughter did not want hospice for him and had hoped that he would get better. On [DATE] at 3:19 PM, a telephone interview was conducted with resident #1's assigned nurse on the day of his death, LPN B. She said that she was a relatively new hire and had started working in the facility the beginning of [DATE]. She said that she worked at the facility on a part-time as needed basis. She said that she was a floating nurse, did not have a permanent assignment, and worked on both nursing units as needed. LPN B said that on [DATE], she worked the 6:30 AM-3 PM shift and was resident #1's assigned nurse. LPN B said that during her shift to shift report, the off going nurse said that resident #1 was fine. She said that at approximately 7:10 AM, she heard CNA C and CNA D call out for her to come into the resident's room. She said RN A was already in the room checking the resident. LPN B stated that she then checked for breathing and a heartbeat with her stethoscope. The resident did not have any vital signs. Contrary to CNA C and D's statement, LPN B said his skin was cool to touch. LPN B stated that RN A had instructed her to turn off the feeding tube, take off his oxygen tubing, and then instructed the two CNAs to clean him up. LPN B said that she and RN A then went to the nurses' station to review his medical record. She said that RN A asked her if he was hospice and then asked to see his paper copy chart. LPN B said RN A reviewed resident #1's paper copy medical record and electronic medical record (EMR). She said, I thought she (RN A) looked through the medical record She said that RN A then called the daughter and the physician. The daughter arrived at the facility about 8 AM. LPN B said that it was not until the SSD approached her later in the afternoon about the resident's passing that she realized he was a full code and that CPR should have been initiated. LPN B stated, I was so overwhelmed by the situation and didn't check for the DNR status because he had already passed. She added that everything was happening so fast that when she asked for help from RN A, she thought RN A had taken charge. LPN B said that she thought RN A had checked for the code status. LPN B said that she had never been involved in a Code Blue at this facility. She said she had been a nurse for about [AGE] years. LPN B stated that she should have checked for the resident #1's code status. On [DATE] at 3:45 PM, a telephone interview was conducted with RN A. She said that on [DATE] at about 7:10 AM, she went into resident #1's room after CNA C and CNA D called out to her. Contrary to CNA C, D and LPN's statements that indicated RN A was first to arrive in the room, RN A said LPN B was already in the room assessing the resident. RN A stated, Looking at him he appeared to be dead. She said that his mouth was open and his eyes were opened and fixed. RN A said that she checked for a pulse and it was absent. She said the resident's arm was cool to touch. This is a discrepancy from CNA C and D's interviews who said that his arm was warm to the touch. RN A said normally, the aides helped and reviewed the chart for code status, but these aides just gathered around. She told them to stop the tube feeding and clean him up. RN A said that she and LPN B went to the nurse's station and that she told LPN B to look in the medical record for his code status. RN A said she began making phone calls to the daughter and physician. She stated that LPN B reviewed the chart and reported to her that the code status was not in the medical chart. RN A said that she found the resident was full code status in the electronic medical record, (EMR) and called the DCS to report this. This contradicted a later interview with the DCS who said that RN A had not informed about the event. RN A then changed her statement and said that she had discovered resident #1 was a full code after the SSD informed her later in the day. RN A said she thought LPN B had already looked at the code status when this all started. She said when a resident has a full code status, that a Code Blue is called, CPR is initiated and 911 is called. RN A said that it was her opinion that the assigned nurse (LPN B) should be responsible for identifying the resident's code status and initiating CPR. She added that she had never performed CPR in this facility, but had practiced with the facility's code blue drills. On [DATE] at 11:42 AM, a telephone interview was conducted with resident #1' daughter. She validated that she was her father's healthcare proxy. She said that on the day that he passed, a nurse at the facility, name unknown, had called her saying that his blood pressure was dropping very low and that she needed to come to the facility right away. She said when she arrived at the facility, he had already passed. She stated the next day, on [DATE], she received a call from the DCS, South wing unit manager, SSD, and the administrator. They informed her that CPR was not performed on her father and that 911 had not been called. The daughter said that she had visited her father on the day before he died , and had spoken to him through his bedroom window due to Coronavirus Disease ,[DATE] (COVID-19) visitation restrictions. She said her father had a hard time talking, but smiled at her. She then asked, Why did the facility not do CPR after they called me and told me his blood pressure was dropping? He was having trouble breathing and they told me to come. She stated, Maybe he could have been brought back if CPR was done. She added, My father was a fighter and wanted CPR. He and I both wanted everything possible to be done. On [DATE] at 1:10 PM, a telephone interview was conducted with the facility's Medical Director who was also resident #1's physician. She said that she was aware that resident #1 had deceased and that CPR had not been initiated as per her orders and the resident's wishes. She said that she thought the nursing staff assumed he was a DNR due to all his comorbidities and a recent decline that required a feeding tube placement. She said that he had recently had a [MEDICAL CONDITION] and stroke. On [DATE] at 9:45 AM and on [DATE] at 3:47 PM, interviews with the administrator and DCS were conducted. During both interviews, the DCS validated that resident #1 was a full code and that CPR should have been initiated when the resident was found unresponsive. She validated the resident had advance directives that indicated he and his daughter wanted CPR to be performed. The DCS stated that RN A and LPN B did not follow facility policies and procedures to call a Code Blue when they found the resident unresponsive. They failed to immediately check for his code status in the medical record, and failed to initiate CPR. She said that after speaking to both nurses, there was confusion over where to find the code status and who was responsible to check the code status. She noted that both nurses claimed that they could not find the code status or an advanced directive indicating he was a full code. She added that the code status of all the residents at that time was located in the front of the paper copy medical record under the Advanced Directives tab. The code status was also noted in the EMR under the resident's profile, and on the resident's Medication Administration Record [REDACTED]#1 not receiving CPR. She said there was a discrepancy as to which nurse first arrived on the scene and would be responsible to take charge. She said there had been confusion and a lack of communication between the nurses and who would take charge of the situation. She said that there was no indication that the nurses had a valid reason for not initiating CPR. Review of the facility's corrective measures implemented by the facility revealed the following: *Chart audits of all current residents was completed by [DATE]. The chart audits comprised of a review of Physician Orders, Medication Administration Record [REDACTED]. Chart audits, by the SSD will continue on daily basis for 1 week, then weekly for 4 weeks. The daily chart audits until [DATE] were verified by the surveyors. *Nursing administration team initiated staff education on the Red Light/Green Light process for validating resident code status. The staff were educated on Abuse, Neglect, Exploitation, Misappropriation and Injuries of Unknown Origin, Resident Rights and the Nurse Practice Act. Additional education was done with the licensed nurses on the Shift Report process regarding physician orders and resident code status. The education included where to find resident code status in the Electronic Health Record (EHR) and in the Medical Record (Hard Chart). As of [DATE], twenty-seven of thirty-five licensed nurse had been educated and post tests conducted. Certified letters were sent to the remaining eight nurses about Code Status verification and these eight nurses will not be permitted to work until all in-service education on resident code status was completed. *The facility initiated mock, Code Blue Drills on [DATE] on all shifts. Previously, the drills were monthly. The PRN (as needed) and nurses on leave will participate in mock, Code Blue Drills, prior to working their next shift. *An ad-hoc Quality Assurance Performance Improvement meeting was held on [DATE] with the participation of the Medical Director, Administrator, DON, SSD, ADON. The Medical Director approved the root caused analysis and correction plan. *On [DATE] at 4:51 PM, the SSD verified that the facility currently had 39 residents with a DNR and 70 residents that were Full Code. *On [DATE] at 2:05 PM a mock Code Blue Drill was observed in room [ROOM NUMBER]. Staff had retrieved the resident's paper chart and brought it to the room. The staff determined that the DNRO was incomplete and not signed and CPR was initiated. After the drill the DCS and ADON were interviewed. They stated that they used several scenarios for the mock Code Blue Drills including incomplete DNRO. They stated that this drill was to test for incorrect DNR status. They stated that this drill was a success and there was a written evaluation done after each drill which were verified. *On [DATE] at 3:47 PM, a meeting held with the Administrator, DCS and Regional Nurse Consultant provided a timeline of events. They stated that their root cause analysis was that the nurses did not verify and locate the resident's code status. The DCS added there was an assumption, due to the resident decline, that the staff assumed the resident was on hospice. The DCS provided clarification that a hospice resident does not mean the resident has an automatic DNRO. She stated this was incorporated in the in-service education. The DCS stated the facility had ensured that the code status was on the 'profile ribbon' on the EHR and the 'profile ribbon' remains at the top of each section of the EHR. The DCS stated that resident code status was the first page on the paper medical chart. Lastly, the DCS stated there was a lack of leadership during the Code Status event on [DATE]. She stated not one of the two nurses that responded took an active

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) leadership role to ensure CPR was initiated. She added as part of their education, the first licensed nurse to arrive/respond was in charge of the Code, regardless of credentials (LPN vs RN). This nurse will delegate tasks and give direction to the staff that respond to the code. This was verified by interviews and during mock Code Blue drills. *Staff interviews with (3 RNs, 3 LPNs and 2 CNAs) revealed the facility had provided education on CPR/Code status and that mock Code Blue Drills were being conducted. The nurses confirmed that the code status of each resident was on the profile section of the EHR and the first page of the paper medical chart. The staff also acknowledged the changes at shift change. Walking rounds with the off going nurse and the on-coming nurse must be done. In addition, at shift change, the off going nurse/on coming nurse must verify each of the resident's code status for that particular assignment. The nurses all stated that they had received CPR/DNRO/Code status training upon hire and re-education since [DATE]. The nurses stated that they had participated in the mock Code Blue Drills. They acknowledged that the first nurse to arrive on the scene during a Code Blue leads the code. They added that 2 licensed nurses must verify code status before the initiation of CPR. The CNAs confirmed that they had received CPR/DNR/Code training upon hire. The CNAs stated that recent education had clarified their responsibilities during a Code Blue. The aides noted that the nurses must verify the resident's code status prior to the initiation of CPR. The CNAs stated the nurse would oversee the Code and they could assist with retrieving the chart, the crash cart, call 911, and other tasks as directed by the charge nurse. All staff confirmed that CPR would continue until relieved by the emergency services personnel or until the resident responded. *Medical record reviews were conducted for 5 current residents. All the residents' code status was quickly found in the EHR and was the first page of the paper medical record.