STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105553	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARROLLWOOD CARE CENTER	**15002 HUTCHINSON RD TAMPA, FL 33625**

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 interviews with facility staff, the resident's family, the resident's Physician and Advanced Registered Nurse Practitioner, a review of residents' clinical records, facility's policy and procedure, and training and code blue drill records, it was determined that the facility failed to protect the rights of one (#1) of 5 sampled residents related to the resident's right to have her wishes honored for her end of life decision, which was not to receive Cardio-Pulmonary Resuscitation should she be found unresponsive. Resident #1, who was [AGE] years old, expressed her wishes to her family for a Do Not Resuscitate Order, should she be found unresponsive, not breathing and without a pulse. The facility did not ensure that all nursing staff knew where to locate residents' end of life decision information in the physical medical record. The facility failed to honor Resident #1 and her family's expressed wishes when her nursing aide found her unresponsive. The nursing staff did not honor the physician's orders [REDACTED]. Staff performed Cardio [MEDICAL CONDITION] Resuscitation (CPR) for fifty five minutes on Resident #1 prior to her being pronounced deceased by the Emergency Medical Services (EMS) called to the scene as part of the resuscitation effort. A resident and family's determination of end of life wishes is a quality of life issue that must be respected by others. The failure of nursing staff to respect the resident's expressed wishes to die naturally when found unresponsive, represented a failure in the facility's system to honor Advance Directives as determined by residents and families. This system failure could lead to not honoring other residents' end of life wishes. On the day that Resident #1 died , the facility census was 112 residents, of which 44 residents had Do Not Resuscitate Orders. The failure of the facility staff to implement Advance Directives correctly resulted in findings of Immediate Jeopardy, past noncompliance, on [DATE]. The Immediate Jeopardy was determined to be corrected on [DATE] before the survey. Findings included: During a review of Resident #1's medical record, a note was reviewed, written by the resident's nurse on [DATE] at 1:03 a.m. , which read: during this evening CNA (Certified Nursing Assistant) went into the resident room to feed resident when she noticed resident unresponsive. CNA immediately notified nurse, checked for breaths and radial pulse, unable to palpate pulse, check DNR for code status, confirmed status, called code. CPR was initiated, staff was with resident until EMS took over. Resident pronounced dead at 6:30 p.m., family member notified. Body was released to funeral home at 10:00 p.m. The Code Blue Worksheet that was completed on [DATE] during the code for Resident #1 was noted to document the event, the time and the person(s) involved . The location of the Code Blue was the resident's room. The worksheet listed the unconscious resident was identified by the aide at 5:30 p.m; at 5:31 p.m. the chart arrived to the resident's room and was checked for the code status order by two nurses; at 5:33 p.m. the emergency cart arrived at the resident's room; at 5:35 p.m. CPR was initiated; at 5:37 p.m. 911 was called; at 5:50 p.m. EMS arrived; at 6:30 p.m. the resident was pronounced deceased . According to the Merriam-Webster Medical Dictionary, the medical definition of Code Blue is the declaration of or a state of medical emergency and call for medical personnel and equipment to attempt to resuscitate a patient especially when in [MEDICAL CONDITION] or respiratory distress or failure. According to the American College of Chest Physicians (US), study at https://journal.chestnet.org/article/S,[DATE] (15),[DATE]/full text: In a prospective study of the complications of cardiac resuscitation, 705 cases were autopsied to identify the cause of death and the pathologic findings attributable to cardiac resuscitation. [MEDICATION NAME] complications were observed in 42.7% of the cases. 31.6%had rib fractures, 21.1% had sternal fractures, and 18.3% were reported as having anterior mediastinal hemorrhage; 20.4% of the cases had an upper airway complication. Abdominal visceral complications were noted in 30.8% of the cases, and [MEDICAL CONDITION] complications occurred in 13% of resuscitation population. Life-threatening complications, such as heart and great vessel injuries, occurred in 5% of the cases. Two notes had been written prior to the note written in the early morning of [DATE] by the resident's nurse. The nurse had written , on [DATE] at 2:46 p.m. notified by Certified Nursing Assistant (CNA) resident had two episodes of emesis, dark in color, this nurse did not see emesis, CNA had already cleaned resident up and tossed dirty linen to laundry, call placed to ARNP (Advance Registered Nurse Practitioner) new order received for [MEDICATION NAME] 4 m p.o. q 4 hrs prn (four milligrams by mouth every four hours as necessary). The next note by the nurse, written at 11:43 p.m.on [DATE] read, resident deceased at 6:30 p.m. this evening, family member was notified, body was released to funeral home at 10 p. Resident #1 resided in a local Assisted Living Facility prior to her admission to the facility after a hospitalization according to the resident's medical record,. According to the Social Services note, dated [DATE], the Resident was admitted to our facility on [DATE] with a [DIAGNOSES REDACTED]. Resident lives at (local) assisted living facility (ALF) and dc (discharge) plan is to return to the Alf. Resident is a full code. A review of the Order Summary Report provided by the facility, confirmed that upon admission, on [DATE], the resident's end of life wishes were for Full Resuscitation. According to the resident's medical record, on [DATE], the Social Services Director wrote, This writer spoke with resident's son regarding POA (Power of Attorney) and Advance Directives. Resident's son agreed to provide a copy of the POA and requested the resident be DNR (Do Not Resuscitate) status. Advance Directives, as referred to by the Social Services Staff, are written instructions for the facility describing what you want done if you cannot voice your wishes because you are incapacitated - your heart has stopped, or you have stopped breathing. It might include a Living Will or a Durable Power of Attorney. (DPOA) A DPOA is the person you have named who you want to speak for you, should you not be able to voice your wishes. The physician's orders [REDACTED]. A physician's orders [REDACTED]. A new care plan was written for the Focus of Advance Directives , initiated on [DATE], for Resident /authorized responsible party request DNR wish to be honored. Interventions included: Discussing the Advance Directives with the resident and/or appointed health care representative; Allowing the resident, if able , to discuss her feelings regarding the Advance Directives; Request the resident and/or appointed health care representative to provide copies to the facility of any updated Advance Directives; Notifying the physician of the resident's wishes regarding life prolonging procedures; DNR status: verify presence of physician's orders [REDACTED]. A follow up note, dated [DATE], and written by Social Services staff read, Resident has impaired cognition and requires extensive assist with ADLs (activities of daily living). Resident is long term placement and DNR status. A new care plan for the Focus area of Discharge Planning, dated [DATE], identified that discharging to a lower level of care may not be feasible, with the goal to adjust to long term care placement. This was a change in the resident's status, as 6 weeks prior, when the resident was admitted on [DATE], with the [DIAGNOSES REDACTED]. At that time the resident had Full Code status. Additional nurse's notes found in the resident's medical record described the resident's declining health status. A progress note written by the Nurse Unit Manager on [DATE] revealed the assessment, Resident is receiving skilled services for complex wound/skin care. Resident cognition is not to person, place, time and situation. The resident's level of

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) cognition is slightly limited (when) responding to verbal commands. A progress note by the Nurse Unit Manager on [DATE] documented, ARNP made aware of weight loss. New orders received. An interview was conducted at 10:34 a.m. on [DATE] with the Social Services Staff member, Staff E, who was asked about the process of obtaining a resident's end of life decisions. She reported that she conducted a welcome conference with newly admitted residents and their families in which goals for discharge were discussed. Staff E explained, The resident's Advance Directives and Code Status are discussed at the initial meeting and if necessary an explanation is provided. If they have an Advance Directive, families are asked to bring any documents in to include in the medical record. Staff E reported that at any time additional conversations can occur with the resident and /or family about the Advance Directives. She continued by saying that any time she meets with the resident and/or family, such as during the quarterly review, the resident's End of Life wishes are discussed including if there are changes they want to make. If a resident has been deemed incapacitated, family is notified, but usually they are involved at that point. Staff E also explained If a resident told her they wanted to change their code status, she would speak with them about the change, but also would refer that conversation to the nurses and they would follow through with the doctor if there needed to be a change in the order. Code Status, as referred to by the Social Services staff, refers to the resident and/or family member's decision as to what they want to happen, should they be found unresponsive and their heart has stopped or they are not breathing. A resident's Code Status can be Full Code, indicating every possible measure available will be used to resuscitate the resident. A Full Code is the process of intervening if a patient's heart stops beating or if the patient stops breathing. It includes cardiopulmonary resuscitation (CPR) which attempts to restart the heart when it has stopped beating. CPR includes chest compressions provided by trained nurses or doctors, which usually takes place before the Emergency Medical Services (EMS) arrive to take over the process of resuscitation and usually get the resident ready to be taken to the hospital for more involved care. The process of resuscitating the patient is often called a code. A resident or family member can also request that medical personnel do not provide any extraordinary means in an attempt to resuscitate, but rather allow the resident to die peacefully, without intervention. This Code Status is a Do Not Resuscitate, or DNR order (DNRO) . Residents and families may look at the end of life as a process that should not be decided by medical personnel providing chest compressions and medications, but rather allow the resident's life to end naturally. Continuing to determine how you want your life to end, is a quality of life issue that must be allowed to be decided by the resident or by those who knew her well. (According to www.Floridahealth.gov) The admission Minimum Data Set (MDS) assessment was conducted on [DATE] which identified the resident as having a short and long term memory problem and her cognitive skills for daily decision making were severely impaired with the resident never or rarely making decisions. The resident's family was involved in the assessment related to her preferences for her daily routine and activities. The MDS Kardex report for the resident included the severely impaired daily decision making, rarely understanding or making herself understood and the nutritional approach of a mechanically altered diet. A baseline care plan developed at admission, dated [DATE], included a focus area of Cardiovascular Disease: The resident has a cardiovascular problem related to [DIAGNOSES REDACTED]. The care plan developed at the time of the admission assessment, dated [DATE], was noted to include the resident's inability to express her ideas or wants, her multiple wounds and potential for pain, alteration in neurological status related to dementia, the use of [MEDICAL CONDITION] medication to manage depression, incontinence that could not be treated with a toileting program due to severe cognitive deficit, her risk for falls due to deconditioning and poor safety awareness that prevented effective teaching , her need for therapy intervention related to her inability to transfer and inability to provide her own care due to weakness and impaired cognition, and therapy for a swallowing deficit and the potential for electrolyte imbalance. A care plan for Activity pursuits documented that the resident required physical assistance from staff for involvement in the activities programs and family reported that Resident #1 enjoyed being outside to listen to the birds or just look at the flowers and plants. She also enjoyed music and watching television, and staff planned to assist her to large group activities during the day. An interview was conducted on [DATE] beginning at 12:53 p.m., with one of the four nurses (Staff Nurse F) who were involved in Resident #1's code blue. She confirmed she checked the resident's medical record for documentation of the Advance Directives upon learning that the resident was unresponsive. Staff Nurse F reported that she had been the acting supervisor on [DATE] and had not taken care of Resident #1 directly. She reported that the agency nurse who was caring for Resident #1, came running to the nurse's station, saying Resident #1 was unresponsive. Staff Nurse F reported that her process was to verify the code status - to look for the documentation in the resident's medical record. She reported that she knew the electronic medical record listed DNR for Resident #1, but the yellow documentation was not in the paper chart. She reported that the yellow form is the documentation that makes the DNR valid. She reported that as there was no yellow document, the DNR code status wasn't verified and she activated the code blue and proceeded to assist with CPR until the Emergency Medical Services (EMS) arrived. Staff Nurse F reported that usually, the DNR was in the front of the chart and when a resident's code status was DNR, the yellow form should be at the front of the chart. She confirmed that at that time, she was only looking for the DNR paper. She confirmed that there was not a valid DNR form, so the patient automatically passed as a full code, even though the status said DNR in the electronic system. Staff Nurse F was referring to the Do Not Resuscitate Order (DNRO) which is a form developed by the Florida Department of Health to identify people who do not wish to be resuscitated in the event of respiratory or [MEDICAL CONDITION]. According to the Florida Department of Health website, (www.floridahealth.gov) the form should only be printed on yellow paper (of any shade), which is what Staff Nurse F was referring to - the yellow form. A DNRO is a physician's orders [REDACTED]. It is part of the prescribed medical treatment plan and must have a physician's signature. Facilities may honor the form, but they may also require their own internal form. This facility developed a policy to require a physician's orders [REDACTED]. A resident may also have the yellow DNRO, but the physician's orders [REDACTED]. A DNRO only means that in the event of respiratory or [MEDICAL CONDITION] that CPR will not be initiated. Comfort care measures, such as oxygen administration, hemorrhage control and pain management will still be used. (According to www.Floridahealth.gov) The Certified Nursing Assistant (Aide H) who cared for Resident #1 was interviewed on [DATE] beginning at 4:54 p.m. She reported that she had worked at the facility for a long time and was working the 3:00 p.m to 11:00 p.m. shifts. She confirmed that she was familiar with Resident #1, who she described as declining, as being totally dependent on her for care and usually wasn't alert. The aide reported that the resident was usually in bed with the television on. She confirmed that she remembered the event that occurred on [DATE] which was around dinner time. She said that she had been in the room with Resident #1 before dinner, had spoken with her and adjusted her blanket. She said that she parked the food cart in front of her room to be able to watch her and after she was done assisting other residents with their meals, she took Resident #1's meal into the room to assist her. The aide reported that the resident was lying in bed with her eyes closed. As that was the resident's normal behavior, she placed her spoon with some of her dinner on it in front of her lips and nose, so she could smell it and know a bite was at her mouth. She said that the resident didn't respond, so she called out to the nurse whom she knew was in the next room. The nurse came right in, checked the resident, and went out into the hall to ask for assistance. As other nurses came into the room, the aide was asked to go to the back door to let the EMS in. She confirmed she had participated in drills and education since then as they were being held to make sure staff know what to do when they find an unresponsive resident. On [DATE] at 5:15 p.m. a call was placed by the surveyor to the resident's family and a message was left requesting a call back. Shortly after, the resident's family member returned the call and confirmed that the family had been notified immediately of the resident's decline. The family member stated that she was aware the facility had called 911 and had started resuscitation. She reported that they had a DNR in place and We were okay with the care they provided. We have no complaints or concerns regarding her care. The family member reported that a care plan meeting was held a few hours before on [DATE], via the phone due to us not being able to visit because of the COVID-19. An interview was conducted with the resident's physician who was also the Medical Director of the facility at 4:15 p.m. on [DATE]. He confirmed that he was familiar with Resident #1, that he was her Primary Physician and that the resident had [DIAGNOSES REDACTED]. He was aware that the POA was the resident's son. The physician reported that he had been told that the resident had gone into [MEDICAL CONDITION], the facility staff coded her, but she expired. The physician reported that he was not aware of her code status, but facility staff called him during the code, and he was told that they tried to resuscitate her. He said that he believed the facility staff wanted to err on the side of caution, so they started CPR and called 911. An interview was conducted on [DATE] at 11:00 a.m. with the resident's ARNP (Advance Registered Nurse Practitioner) who confirmed she was familiar with the resident. The ARNP reported that she was aware the resident had been admitted from a local assisted living facility with a right hip wound. She described the resident as needing total assistance for all care and also that she had Dementia. She was aware that there was family involvement and confirmed she had spoken with them by phone when the resident was first admitted . The ARNP reported that

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F 0578 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) could not remember the resident's code status and whether or not the resident had an incapacity statement. She reported she had been contacted after the resident died as she wasn't in the facility at that time. She was told the resident was found unresponsive, had been given CPR and EMS had been called. When the ARNP was told, during the phone call, that the resident had a DNRO, she confirmed that the DNRO would not include staff providing CPR. She reported that she wasn't sure about the facility's policy for checking code status and didn't know if the staff was directed to look for the yellow DNRO form exclusively or not. An interview was conducted with the Unit Manager, Staff A on [DATE] beginning at 11:30 a.m. who confirmed she had been working on the day Resident #1 was found unresponsive. She said that she wasn't really involved directly as she was at the desk, watching what was going on. She reported that she didn't know who checked the chart for the code status or where they looked or what they saw. She confirmed that there had been a lot of education since the event, including drills, in which the facility learned that the aides were not participating in as they knew they couldn't do compressions. But now they are encouraged to be involved, as they can be runners or lead the EMS staff to the resident. When staff A was asked when the resident's code status was discovered, she reported that it wasn't until the next morning when the clinical team had their morning meeting that they realized providing CPR was wrong. She said when they discussed the events of the prior 24 hours, someone saw that the resident had a DNR order and not a full code order, and they shouldn't have performed CPR on the resident. She said the nurses who were involved in the code confirmed they were looking for the yellow DNR form. Staff A was not able to say when the last time the staff had been educated on the facility policy of determining a resident's code status. She confirmed that the facility policy was to look for the physician's orders [REDACTED]. recent as those nurses, involved in the code, did not know what to look for. (While she was stating this, she pulled a resident's medical record over, flipped open the front cover, and pointed to the telephone order inside the plastic sleeve indicating the code status. It was the first page in the medical record.) The Unit Manager confirmed that she knew the resident a little as the resident had lived on one of her halls for a few weeks. She said the resident was quiet, didn't talk much and came to them with multiple wounds. She said the resident was gotten out of bed daily but didn't really participate in activities - just watched. She said with the current social distancing, residents had their days when they were gotten out of bed, and that day was not her day to be up. She said she spoke with the family that morning as the resident was looking good and the wounds were looking good. She said she never would have thought anything like that would have happened. An interview was conducted with the Staff Development Coordinator, Staff G, on [DATE], beginning at 1:50 p.m. She reported she had been on staff for about a year and had conducted education on Advance Directives prior to the incident that occurred on [DATE], but she couldn't recall how often or when. She confirmed she knew Resident #1 as alert, but not oriented, not able to make her needs known, and requiring total care. She reported that she provided wound care to the resident and her wounds were extensive. She reported they were slowly healing, certainly not worsening, but she never complained or even looked like she was in pain. She remembered the resident as having been in the facility for several months. Staff G reported that she was getting ready to leave for the day and heard the code called so she went down to assist. She said when she got to the room, she observed compressions had been started by two male nurses. She said she wasn't aware of the resident's code status and in another situation, she would have grabbed the chart to check the status. She confirmed that the code status is kept right in the front of the chart, but you can check the electronic record also. She reported that nurses know not to start CPR until they confirm the code status. She remembered telling the nurses at the nursing station to bring the chart to the room as the paramedics would want it when they came in. An interview was conducted with a facility Registered Nurse, RN N on [DATE] beginning at 11:45 a.m. She reported that she had worked at the facility for a long time and knows to check a resident's code status by opening the front of the resident's medical record. She said that the physician's orders [REDACTED]. She said the electronic medical record also has the code status. She confirmed she attended recent education on Advance directives and there had been many code blue drills conducted within the last month. She pointed to a small cart, indicating that was the code cart. The equipment was covered with a heavy plastic cover and it sat against the wall in a niche across from the nursing station. She pointed to the big STOP sign attached to cover, which she said was a reminder to 'check the code status'. She confirmed she had been Resident #1's nurse at times and found her to be alert, but confused and not able to say what she needed. She kept her eyes closed most of the time, if she was in bed or sitting in her wheelchair at the nurses stations. She knew that aides had taken her to activities, or outside when it was nice, but recently she spent most days in bed , with her television on. Interviews were conducted with staff during the survey that was conducted on ,[DATE], ,[DATE] and [DATE] to ensure that they had attended in-services on the facility's policy for Advance Directives and participated in code blue drills. Of the 17 interviews conducted with nurses, 6 interviews confirmed either that staff thought the policy was new or that the yellow form needed to be visualized as well as the physician's orders [REDACTED]. In addition to Staff F, Staff B, C, T, V and J thought the in services they were attending that began on [DATE] were discussing a new policy. These six staff reported that they used to look for the yellow form to determine a resident's code status. They reported that the policy must have changed because now the policy is to look for the physician's orders [REDACTED]. An interview was conducted with a Licensed Practical Nurse, Staff B, at 11:25 a.m. on [DATE]. He confirmed that he had worked at the facility for years. He confirmed that he had received lots of education with code blue drills lately. When asked where he would find the Advance directives, he replied - inside the resident's chart, you look for the doctor's order. At that time, he picked up a resident's chart, opened the front cover and pointed to the physician's orders [REDACTED]. When he was asked about the yellow DNR form, he said, no, we used to look for that but now it's the doctor's order we look for, which he continued by saying, , I like that, it's easy. When he was asked if that was a change from an old process, the LPN replied, Yeah, I think so, we used to look for the yellow form. On [DATE] at 9:15 a.m. an interview was conducted with LPN C, who confirmed she usually worked the 7 to 3 shifts, and she was assigned to any of the halls. She confirmed that she had received training within the last month on Advance directives and had participated in drills. When asked what her process was if she found a resident who was unresponsive, she reported she would check the resident's medical record for the first page inside which would have the telephone order. She said she would check if the resident was a full code and if so, then would call the code and get the cart. Staff nurse T was interviewed by phone at 9:45 a.m. on [DATE] and she confirmed that the doctor's order for code status was found on the first page, inside of the medical record. She reported that she felt that information was a change, but not a recent change, maybe in place for the last year or so. She confirmed that they always used to check for the yellow form, but now, or for the last year, they were to check just inside the medical record for the order. She confirmed she always worked 11:00 p.m. to 7:00 a.m. and staff have come in to ensure the 11:00 p.m to 7:00 a.m staff knew the process. She reported they had had code drills to ensure they all were familiar with the code process and where to find the code status. A full-time nurse, Staff V was interviewed on [DATE] beginning at 10:30 a.m. She confirmed she had attended training and drills once or twice a week for the last month. She reported that she thought it was a new policy and was a little unhappy that staff were not kept up to date with policy changes. She confirmed that it was important to know the telephone order was kept just inside of the medical record. She reported that she had seen the order there, but she would usually look under the Advance Directive tab for the yellow form as well. Staff V confirmed she had cared for Resident #1 a few times. She remembered her because of her wounds , which were extensive. She said she had come from an ALF and thought it was bad to have such bad wounds. She was glad when it was apparent the resident wouldn't be returning to the ALF. She said the resident was always in bed, very seldom did she see the resident up at the nursing station or in activities. On [DATE] beginning at 3:37 p.m., Staff J was interviewed, and she confirmed that she had worked part time at the facility for over one year. She stated when a resident is found unresponsive the nurses call a code and check the code status. She said that someone gets the code cart and joins the group until the resident's code status is confirmed She reported that it was the physician's orders [REDACTED]. An interview was conducted on [DATE] beginning at 12:00 p.m. with Unit Manager M, who confirmed she had worked at the facility for about one month. She reported that she learned during orientation that a resident's code status could be found inside of the resident's medical record. She reported that she was in the building on [DATE] when the code blue was called for Resident #1 and had arrived at the event once it was underway. She said she did not check the chart herself for code status, as it seemed others had. She said that she took the times for the code. She confirmed that she has participated in Advance directive training, including [MEDICATION NAME] codes. An interview was conducted with Registered Nurse O on [DATE] beginning at 11:50 a.m. She confirmed she worked full time, usually on the same hall and on the 7:00 a.m. to 3:00 p.m. shift. She confirmed that code status was found right inside of the chart and the facility used the physician's orders [REDACTED]. She pulled a resident's chart over, flipped open the cover and pointed to the plastic sleeve containing a physician's orders [REDACTED]. She confirmed there had been education on Advance directives and code blue drills conducted within the last month. An interview was conducted with a Licensed Practical Nurse P on

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F 0578 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) ,[DATE]
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 interviews with the Nursing Home Administrator (NHA) , the Director of Nurses (DON) , nursing staff, the resident's Physician, the Advanced Registered Nurse Practitioner (ARNP) , and a family member, and review of the resident's medical record , facility policy and procedures, and in-service trainings, it was determined that the facility failed to follow their policy related to honoring a resident's end of life wishes, for one (Resident #1) of five sampled residents. Resident #1, who was [AGE] years old, expressed her wishes to her family, for a Do Not Resuscitate Order, should she be found unresponsive, not breathing and without a pulse. The facility neglected to ensure all nursing staff were competent in their ability to implement the facility policy related to following the physician's orders [REDACTED]. When Resident #1 was found unresponsive by her nursing aide, the nursing staff disregarded the physician's orders [REDACTED]. The resident endured CPR for fifty-five minutes prior to being pronounced deceased by the Emergency Medical Services. The failure of nursing staff to implement the facility policy related to honoring a resident's end of life wishes represented a facility system failure that had the potential to affect all residents in the facility, if their expressed end of life wishes were neglected and not honored. According to the Administrator and the Director of Nurses, training on the policy related to residents' end of life wishes was routinely provided, but it wasn't until after the incident which occurred on [DATE], that nurses were required to complete a post test and all staff were required to participate in code blue drills. By not verifying staff's knowledge and ability to implement facility policy, the facility failed to ensure staff did not neglect a basic right of one resident's end of life wishes, by not honoring a DNR order for Resident #1. On the day that Resident #1 died , the facility census was 112 residents, of which 44 residents had Do Not Resuscitate Orders. The failure of the facility staff to implement Advance Directives correctly resulted in findings of Immediate Jeopardy, past noncompliance, on [DATE]. The Immediate Jeopardy was determined to be corrected on [DATE] before the survey. Findings included: The facility's policy on their Abuse Prevention Program (Effective 2012 with a Change date of [DATE]) was reviewed and noted to include in the Policy statement the following: The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment and misappropriation of resident's property. These policies guide the identification, management and reporting of suspected or alleged, abuse, neglect, mistreatment and exploitation. It is expected that these policies will assist the facility with reducing the risk of abuse, neglect, exploitation and misappropriation of residents' property through education of staff and residents, as well as early identification of staff burn out, or resident behavior which may increase the likelihood of such events. Included under the Definition of Abuse was Deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial wellbeing. Neglect was defined in the Policy as: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Review of the 2020 Education Calendar revealed the program planned for March was Abuse, Neglect, Exploitation, Misappropriation, Elder Justice Act examples and reporting requirements. The Audience was all staff and an Abuse Post Test was required by all staff. In May, a planned program was listed as Advance Directives Policy Review, Advance Directives Documents and honoring wishes and code blue review, and CPR Skills / role. This program was for both nurses and aides, with CPR training to be provided to nurses whose certification in CPR expired within the next six months. Competencies for this training were listed as Advance Directive Audit and Code Blues. The Administrator provided documentation of Abuse Training that occurred prior to Resident #1 being found unresponsive on [DATE]. One in-service training record, dated [DATE], was provided, with 27 staff signatures, with the Objective of Abuse, Neglect, Exploitation, Misappropriation. On [DATE], the Administrator reported that she had 177 staff currently, which included contract staff. Review of Annual Education/Inservice Record for Employees found Abuse and Neglect training had occurred on ,[DATE], ,[DATE] and [DATE], according to a review of in-service records for Staff F, H, A, and G. In an interview with the Administrator on [DATE] at 11:41 a.m., she reported that 2 of the 4 nurses who had been present to assist with resuscitating Resident #1 were agency nurses. A review was conducted of the Orientation Checklist that was provided to the agency employees prior to the start of their shift, according to Staff D, the Staffing Coordinator on [DATE] in an interview that began at 10:05 a.m. The checklist included ten topics related to facility policy and procedure that the employee initialed as having been made aware. The topic of Abuse, Neglect & Exploitation of residents, with the addition of abuse must be reported to your supervisor and NHA and seven statements from the policy were included on the document. Also included on the checklist was the topic of Code Status Order and Response related to the Code Blue process - Commitment to Honoring Advance Directives. The first four points in the Code Blue Process included: a) immediately call for help; b) evaluate pulse/heart rate and respirations; c) review code status at source document (physician's orders [REDACTED]. Resident #1 resided in a local Assisted Living Facility prior to her admission to the facility after a hospitalization . According to the Social Services note, dated [DATE], the Resident was admitted to our facility on [DATE] with a [DIAGNOSES REDACTED]. Resident lives at (local) assisted living facility (ALF) and dc (discharge) plan is to return to the Alf. Resident is a full code. A review of the Order Summary Report for the days of the resident's stay confirmed that upon admission, on [DATE], the resident's end of life wishes were for Full Resuscitation. A review was made of the resident's [DIAGNOSES REDACTED]. A review of daily progress notes revealed the resident had multiple pressure wounds on her left trochanter and left heel, which were present on admission and according to doctor's orders, were treated daily. Included in the baseline care plan, developed at admission and dated [DATE], was a focus area of Cardiovascular Disease: The resident has a cardiovascular problem related to [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment was conducted on [DATE] which identified the resident as not able to participate in the Brief Interview for Mental Status (BIMS) assessment. The resident was assessed as having a short and long term memory problem and her cognitive skills for daily decision making was severely impaired with the resident never or rarely making decisions. Family was involved in the assessment related to her preferences for her daily routine and activities. The MDS Kardex report for the resident included the severely impaired daily decision making, rarely understanding or making herself understood and the nutritional approach of a mechanically altered diet. A care plan was developed at the time of the admission assessment, dated [DATE], and noted to include the resident's inability to express her ideas or wants, her multiple wounds and potential for pain, alteration in neurological status related to dementia, the use of [MEDICAL CONDITION] medication to manage depression, incontinence that could not be treated with a toileting program due to severe cognitive deficit, her risk for falls due to deconditioning and poor safety awareness that prevented effective teaching , her need for therapy intervention related to her inability to transfer and inability to provide her own care due to weakness and impaired cognition, and therapy for a swallowing deficit and the potential for electrolyte imbalance. The resident was identified as requiring staff assistance for involvement in the activities programs and family reported that Resident #1 enjoyed being outside to listen to the birds or just look at the flowers and plants. She also enjoyed music and watching television, and staff planned to assist her to large group activities during the day. A care plan with the Focus area of Discharge Planning was initiated on [DATE] indicating the resident wished / or Responsible Party wished to discharge to an ALF (assisted living facility). An interview was conducted at 10:34 a.m. on [DATE] with the Social Services Staff member, Staff E, who was asked about the process of obtaining a resident's end of life decisions. She reported that she conducted a welcome conference with newly admitted residents and their families in which goals for discharge were discussed. The resident's Advance Directives and Code Status were discussed at the initial meeting and if necessary, an explanation was provided. She reported that if the resident had an Advance Directive, we ask that they bring any documents in for us to include in the medical record. At any time, additional conversations can occur with the resident and /or family about the Advance Directives. Any time we meet with the resident and/or family, such as the quarterly review, we discuss the resident's End of Life wishes and ask if there are changes they want to make. If a resident had been deemed incapacitated, we would notify the family, but usually they would be involved at that point. If a resident told me they wanted to change their code status, I would speak with them about the change, but also would refer that conversation to the nurses and they would follow through with the doctor if there needed to be a change in the order. Advance Directives, as referred to by the Social Services Staff, are written instructions for the facility describing what you want done if you cannot voice your wishes because you are incapacitated - your heart has stopped, or you have stopped breathing. It might include a Living Will or a Durable Power of Attorney. (DPOA) A DPOA is the person you have named who you want to speak for you, should you not be able to voice your wishes. For

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Resident #1, her son was her DPOA. . According to the resident's medical record, on [DATE], the Social Services Director wrote, This writer spoke with resident's son regarding POA and Advance Directives. Resident's son agreed to provide a copy of the POA and requested the resident be DNR (Do Not Resuscitate) status. The resident's son was contacted by the facility to discuss the resident's end of life wishes as the facility, through interviews and working with the resident for over one month, were aware that the resident was not able to make decisions for herself and that her health was declining. The Social Services Director's follow up note, dated [DATE], read, Resident has impaired cognition and requires extensive assist with ADLs (activities of daily living). Resident is long term placement and DNR (Do Not Resuscitate) status. This was a change in the resident's status, as 6 weeks prior, when the resident was admitted on [DATE], with the [DIAGNOSES REDACTED]. At the time of admission the resident had Full Code status. A care plan which included the focus area of Advance Directives , dated [DATE], was initiated for resident/authorized responsible party request Do Not Resuscitate (DNR) wish to be honored. Review of Physician order [REDACTED]. Code Status, as referred to by the Social Services staff, refers to the resident and/or family member's decision as what they want to happen, should they be found unresponsive and their heart has stopped, or they are not breathing. A resident's Code Status can be Full Code, indicating every possible measure available will be used to resuscitate the resident. A Full Code is the process of intervening if a patient's heart stops beating or if the patient stops breathing. It includes cardiopulmonary resuscitation (CPR) which attempts to restart the heart when it has stopped beating. CPR includes chest compressions provided by trained nurses or doctors, which usually takes place before the Emergency Medical Services (EMS) arrive to take over the process of resuscitation and usually get the resident ready to be taken to the hospital for more involved care. The process of resuscitating the patient is often called a code. Initially the plan for discharge after Resident #1's medical status improved was to return to the Assisted Living Facility. A new care plan focus was dated [DATE] which identified that discharging to a lower level of care may not be feasible, with the goal to adjust to long term care placement. Nursing progress notes reflected the decline in the Resident #1's status. Progress notes written by the Nurse Unit Manager on [DATE] revealed the assessment, Resident is receiving skilled services for complex wound/skin care. Resident cognition is not to person, place, time and situation. The resident's level of cognition is slightly limited (when) responding to verbal commands. A progress note by the Nurse Unit Manager on [DATE] documented, ARNP made aware of weight loss. New orders received. During a review of Resident #1's medical record a nurse's note was reviewed, written on [DATE] at 1:03 a.m., which read, During this evening CNA went into the resident room to feed resident when she noticed resident unresponsive. CNA immediately notified nurse, checked for breaths and radial pulse, unable to palpate pulse, check DNR for code status, confirmed status, called code. CPR was initiated, staff was with resident until EMS took over. Resident pronounced dead at 6:30 p.m., family member notified. Body was released to funeral home at 10:00 p.m. An earlier note written by the resident's nurse on [DATE] at 2:46 p.m. read, Notified by Certified Nursing Assistant (CNA) resident had two episodes of emesis, dark in color, this nurse did not see emesis. CNA had already cleaned resident up and tossed dirty linen to laundry, call placed to ARNP (Advance Registered Nurse Practitioner) new order received for [MEDICATION NAME] 4 m p.o. q 4 hrs. prn (four milligrams by mouth every four hours as necessary). On [DATE] at 11:43 p.m. a nurses note read, Resident deceased at 6:30 p.m. this evening, family member was notified, body was released to funeral home at 10:00 p.m. The Code Blue Worksheet, completed for Resident #1 by Staff member M, to document the event, time and person involved during a code blue was reviewed. According to the Code Blue Worksheet for Resident #1, the Unconscious Resident was identified at 5:30 p.m. on [DATE] by Staff H; the resident's medical record was brought to the room and it was checked for the code status order at 5:31 p.m. ; at 5:33 p.m. the emergency cart arrived to the resident's room brought by agency nurse L; CPR was initiated at 5:35 p.m.; 911 was called at 5:37 p.m. and arrived at 5:50 p.m.; and the resident was pronounced deceased at 6:30 p.m. According to the Merriam-Webster Medical Dictionary, the medical definition of Code Blue is the declaration of or a state of medical emergency and call for medical personnel and equipment to attempt to resuscitate a patient especially when in [MEDICAL CONDITION] or respiratory distress or failure. According to the American College of Chest Physicians (US), study at https://journal.chestnet.org/article/S,[DATE](15),[DATE]/full text: In a prospective study of the complications of cardiac resuscitation, 705 cases were autopsied to identify the cause of death and the pathologic findings attributable to cardiac resuscitation. [MEDICATION NAME] complications were observed in 42.7% of the cases. 31.6%had rib fractures, 21.1% had sternal fractures, and 18.3% were reported as having anterior mediastinal hemorrhage; 20.4% of the cases had an upper airway complication. Abdominal visceral complications were noted in 30.8% of the cases, and [MEDICAL CONDITION] complications occurred in 13% of resuscitation population. Life-threatening complications, such as heart and great vessel injuries, occurred in 5% of the cases. An interview was conducted on [DATE] beginning at 4:54 p.m. with the Nursing Aide (Staff H) who cared for Resident #1 on [DATE]. She confirmed she had been an aide at the facility for many years and was currently assigned to the 3:00 p.m.-11:00 p.m. shift. She confirmed she had been caring for Resident #1 and knew her well. She reported that the resident was declining and was totally dependent on her for all of her care, including assistance at meals. She said that the resident was not alert and remained in bed most of the time with the television on. She confirmed that she had worked with Resident #1 on the day she died and had found the resident unresponsive when she tried to assist her with dinner. She explained that she visited with Resident #1 right before the dinner trays came out and adjusted the covers around her shoulders. She said that she assisted the other staff with passing meal trays to residents and assisted some residents with their meals. She said she left Resident #1 for last and when she was done with the other residents, she took the dinner tray into Resident #1. She said that Resident #1 was lying in bed with her eyes closed, but that was the resident's normal behavior. She said that she held the spoon with a bite of dinner under Resident #1's nose and up to her lips, but there was no response from Resident #1. She said she called out for the nurse, as she had just seen the nurse in the next room. The nurse came right away, and then went out to the hall to call for help. She reported that other nurses came into the room and she was told to go to the back door to let Emergency Medical Services (EMS) in. An interview was conducted over the phone, on [DATE] beginning at 12:53 p.m. with the nurse (Staff F) who was involved in the resident's resuscitation code. Staff F confirmed that she had worked as the acting supervisor on the 3:00 p.m. to 11:00 p.m. shift on [DATE] and had not taken direct care of Resident #1 that day. She reported that an agency nurse assigned to Resident #1 came running to the nursing station saying that the resident was unresponsive. She confirmed she checked the resident's medical record for documentation of the advance directives upon hearing that the resident was unresponsive. Staff F reported that her process was to verify the code status by checking the documentation in the resident's medical record. She reported that she knew the electronic medical record listed DNR for Resident #1, but the yellow documentation was not in the paper chart. She reported that the yellow form is the documentation that makes the DNR valid. She reported that as there was no yellow document, the DNR code status wasn't verified and she activated the code blue and proceeded to assist with CPR until the Emergency Medical Services (EMS) arrived. Staff F reported that usually the DNR form was in the front of the chart and when a resident's code status was DNR, the yellow form should be at the front of the chart. She confirmed that at that time, she was only looking for the DNR paper. She confirmed that there was not a valid DNR form, so the patient automatically passed as a full code, even though the status said DNR in the electronic system. Staff F was referring to a Do Not Resuscitate Order (DNRO) which is a form developed by the Florida Department of Health to identify people who do not wish to be resuscitated in the event of respiratory or [MEDICAL CONDITION]. According to the Florida Department of Health website, www.floridahealth.gov, the form should only be printed on yellow paper (of any shade), which is what Staff F was referring to - the yellow form. A DNRO is a physician's orders [REDACTED]. It is part of the prescribed medical treatment plan and must have a physician's signature. Facilities may honor the form, but they may also require their own internal form. This facility developed a policy to require a physician's orders [REDACTED]. A resident may also have the yellow DNRO, but the physician's orders [REDACTED]. A DNRO only means that in the event of respiratory or [MEDICAL CONDITION] that CPR will not be initiated. Comfort care measures, such as oxygen administration, hemorrhage control and pain management will still be used. (According to www.floridahealth.gov) On [DATE] at 5:15 p.m. a call was placed by the surveyor to the resident's family and a message was left requesting a call back. Shortly after, the resident's family member returned the call and confirmed that the family had been notified immediately of the resident's decline. The family member stated that she was aware the facility had called 911 and had started resuscitation. She reported that they had a DNR in place and we were okay with the care they provided. We have no complaints or concerns regarding her care. The family member reported that a care plan meeting was held a few hours before on [DATE], via the phone due to us not being able to visit because of the COVID-19. An interview was conducted with the resident's physician who was also the Medical Director of the facility at 4:15 p.m. on [DATE]. He confirmed that he was familiar with Resident #1, that he was her Primary Physician and that the resident had [DIAGNOSES REDACTED]. He was aware that the POA was the resident's son. The physician reported that he had

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) been told that the resident had gone into [MEDICAL CONDITION], the facility staff coded her, but she expired. The physician reported that he was not aware of her code status, but facility staff called him during the code, and he was told that they tried to resuscitate her. He said that he believed the facility staff wanted to err on the side of caution, so they started CPR and called 911. An interview was conducted on [DATE] at 11:00 a.m. with the resident's ARNP (Advance Registered Nurse Practitioner) who confirmed she was familiar with the resident. The ARNP reported that she was aware the resident had been admitted from a local assisted living facility with a right hip wound. She described the resident as needing total assistance for all care and also that she had Dementia. She was aware that there was family involvement and confirmed she had spoken with them by phone when the resident was first admitted . The ARNP reported that she could not remember the resident's code status and whether or not the resident had an incapacity statement. She reported she had been contacted after the resident died as she wasn't in the facility at that time. She was told the resident was found unresponsive, had been given CPR and EMS had been called. When the ARNP was told, during the phone call, that the resident had a DNRO, she confirmed that the DNRO would not include staff providing CPR. She reported that she wasn't sure about the facility's policy for checking code status and didn't know if the staff was directed to look for the yellow DNRO form exclusively or not. An interview was conducted with a Unit Manager, Staff A, on [DATE] beginning at 11:30 a.m. She confirmed she had been working on [DATE], the day that Resident # 1 was found unresponsive, was provided with CPR and ultimately died . She said she remained at the desk and was not involved directly with the code. She reported that she did not know who checked the chart for the code status or where they looked or what they saw. She confirmed that there had been a lot of education since the event, including drills, in which the facility learned that the aides were not participating in the codes. The aides reported that as they couldn't do the compressions, they didn't think they were to participate. But since the training, they are encouraged to be involved, as they could be runners or lead the EMS staff to the resident. Staff A was asked when or how the resident's code status was discovered. She reported that it wasn't until the next morning when the clinical team had their morning meeting that they realized providing CPR was wrong. She said when they discussed the events of the prior 24 hours, someone saw that the resident had a DNR order and not a full code order, and they shouldn't have performed CPR on the resident. She said the nurses who were involved in the code confirmed they were looking for the yellow DNR form. Staff A was not able to say when the last time the staff had been educated on the facility policy of determining a resident's code status. She confirmed that the facility policy was to look for the physician's orders [REDACTED]. recent as those nurses involved in the code did not know what to look for. (While she was stating this, she pulled a chart over, flipped open the front cover, and pointed to the telephone order inside the plastic sleeve indicating the code status. It was the first page in the medical record.) Staff A confirmed that she knew Resident #1 a little as the resident had lived on one of her halls for a few weeks. She said the resident was quiet, didn't talk much and came to them with multiple wounds. She said the resident was assisted out of bed daily but didn't really participate in activities - just watched. She said with the current social distancing, residents had their days when they were assisted out of bed, and that day was not her day to be up. She said she spoke with the family that morning as the resident was looking good and the wounds were looking good. She said she, Never would have thought anything like that would have happened. An interview was conducted with the Staff Development Coordinator, Staff G, on [DATE], beginning at 1:50 p.m. She reported she had been on staff for about a year and had conducted education on Advance Directives prior to the incident that occurred on [DATE], but she couldn't recall how often or when. She confirmed she knew Resident #1 as alert, but not oriented, not able to make her needs known, and requiring total care. She reported that she provided wound care to the resident and her wounds were extensive. She reported they were slowly healing, certainly not worsening, but she never complained or even looked like she was in pain. She remembered the resident as having been in the facility for several months. Staff G reported that she was getting ready to leave for the day and heard the code called so she went down to assist. She said when she got to the room, she observed compressions had been started by two male nurses. She said she wasn't aware of the resident's code status and in another situation, she would have grabbed the chart to check the status. She confirmed that the code status is kept right in the front of the chart, but you can check the electronic record also. She reported that nurses know not to start CPR until they confirm the code status. She remembered telling the nurses at the nursing station to bring the chart to the room as the paramedics would want it when they came in. An interview was conducted with a facility Registered Nurse, RN N on [DATE] beginning at 11:45 a.m. She reported that she had worked at the facility for a long time and knows to check a resident's code status by opening the front of the resident's medical record. She said that the physician's orders [REDACTED]. She said the electronic medical record also has the code status. She confirmed she attended recent education on Advance directives and there had been many code blue drills conducted within the last month. She pointed to a small cart, indicating that was the code cart. The equipment was covered with a heavy plastic cover and it sat against the wall in a niche across from the nursing station. She pointed to the big STOP sign attached to cover, which she said was a reminder to 'check the code status'. She confirmed she had been Resident #1's nurse at times and found her to be alert, but confused and not able to say what she needed. She kept her eyes closed most of the time, if she was in bed or sitting in her wheelchair at the nurses stations. She knew that aides had taken her to activities, or outside when it was nice, but recently she spent most days in bed , with her television on. Interviews were conducted with staff during the survey that was conducted on ,[DATE], ,[DATE] and [DATE] to ensure that they had attended in-services on the facility's policy for Advance Directives and participated in code blue drills. Of the 17 interviews conducted with nurses, 6 interviews confirmed either that staff thought the policy was new or that the yellow form needed to be visualized as well as the physician's orders [REDACTED]. In addition to Staff F, Staff B, C, T, V and J thought the in services they were attending that began on [DATE] were discussing a new policy. These six staff reported that they used to look for the yellow form to determine a resident's code status. They reported that the policy must have changed because now the policy is to look for the physician's orders [REDACTED]. An interview was conducted with a Licensed Practical Nurse, Staff B, at 11:25 a.m. on [DATE]. He confirmed that he had worked at the facility for years. He confirmed that he had received lots of education with code blue drills lately. When asked where he would find the advance directives, he replied - Inside the resident's chart, you look for the doctor's order. At that time, he picked up a resident's chart, opened the front cover and pointed to the physician's orders [REDACTED]. When he was asked about the yellow DNR form, he said No, we used to look for that but now it's the doctor's order we look for, which he continued by saying, I like that, it's easy. When he was asked if that was a change from an old process, the LPN replied, Yeah, I think so, we used to look for the yellow form. On [DATE] at 9:15 a.m. an interview was conducted with the LPN, Staff C, who confirmed she usually worked the 7:00 a.m. to 3:00 p.m. shifts, and she could be assigned to any of the halls. She confirmed that she had received training within the last month on advance directives and had participated in drills. When asked what her process was if she found a resident who was unresponsive, she stated she would check the resident's medical record for the first page inside which would have the telephone order. She stated she would check if the resident was a full code and if so, then would call the c