STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105670	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTE AT ST CLOUD INC	**1301 KANSAS AVE 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 4 sampled resident in a total sample of 5 residents reviewed for code status, (#1). Resident #1 had advance directives and physician's order that did not include withholding of cardio-pulmonary resuscitation (CPR). On [DATE] at approximately 2:30 AM, resident #1 was found unresponsive in bed with the absence of vital signs. The resident's primary nurse, Licensed Practical Nurse (LPN) A failed to verify the resident's code status which included Cardiopulmonary Resuscitation to be initiated. LPN A 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 Immediate Jeopardy beginning on [DATE]. The Immediate Jeopardy was removed on [DATE]. Findings: Resident #1 was a long-term care resident admitted to the facility on [DATE]. He was hospitalized on [DATE] and readmitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. The resident was placed in the facility's COVID-19 unit when he was readmitted . The facility's policies and procedure for Cardiopulmonary Resuscitation (CPR) dated [DATE] and revised on [DATE] included the following: The facility will follow current American Heart Association (AHA) guidelines regarding CPR. If a resident experiences a [MEDICAL CONDITION], facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and a. in accordance with the resident's advance directives, or b. in the absence of advance directives or a Do Not resuscitate order or c. if the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition). CPR sequence- check patient for responsiveness. If unresponsive, call for help and activate EMS, or direct others to do so .check for breathing and pulse. If no pulse and not breathing, begin CPR cycle .CPR will be continued: until EMS arrives or until resident regains spontaneous circulation or Until medical provider is called, resident condition is discussed/described, and provider gives order to discontinue resuscitative efforts. The CPR During COVID-19 Pandemic- Interim Policy dated [DATE] read, If a resident experiences a [MEDICAL CONDITION], facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and a. in accordance with the resident's advance directives, or b. in the absence of advance directives or a Do Not resuscitate order or c. if the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) .Staff will don appropriate PPE prior to initiation of CPR: eye protection, N95 respirators (preferred), gloves, and gowns. Four sets of PPE will be placed on all crash carts. An appropriate bag-mask device with tight seal will be on all crash carts and immediately obtained for rescue breathing .The number of people in the room will be limited to essential personnel (i.e. those with active duties such as compressions and airway management). Each person in the room must wear appropriate PPE. All other essential staff (i.e. runners, scribe) shall remain in the hall at the doorway. The facility's policy and procedure: Advance Directives dated ,[DATE] included: In the event that a resident experiences cardiopulmonary arrest the nurse on duty shall immediately determine the resident's status as a code or no code. If the person is a full code, the nurse or designee shall begin Cardiopulmonary Resuscitation and direct someone to call 911. Review of the medical record revealed resident #1's physician orders dated [DATE] read, Full code. LPN A's progress note on [DATE] at 3:49 AM read, [DATE] 0115 (1:15 AM) Resident resting in bed comfortably with eyes closed alert and responsive, no s/s (signs and symptoms) of distress. [DATE] 0230 (2:30 AM) check on him see if he is okay, if needed to be reposition (repositioned). Found him unresponsive, not breathing, no pulse, could not get a BP. 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. Code Blue: An emergency situation announced in a hospital or institution in which a patient is in cardiopulmonary arrest, requiring a team of providers (sometimes called a code team) to rush to the specific location and begin immediate resuscitative efforts. (MedicineNet.com website at https://www.medicinenet.com/meaning_of_code_black_and_code_blue/views.htm accessed on [DATE] at 2:15 PM). On [DATE] at 7:12 AM, LPN C walked toward her medication cart. At that time, an interview was conducted with her. She stated that she received in-service regarding CPR and Advance Directives about 2 to 3 months ago and had not received any in-service or re-education recently on CPR or Advance Directives since [DATE]. Review of the facility's Education In-service Attendance Record did not find LPN C's name identified. On [DATE] at 8:51 AM, the Executive Director (ED) stated that the facility's investigation revealed that the nurse caring for resident #1 (LPN A), identified no pulse, or blood pressure, and because of the condition he was in- showing signs of dependent lividity, CPR was not initiated. Dependent lividity is hypostasis of the blood following death that causes a purplish red discoloration of the skin. (Merriam-Webster Medical Dictionary at https://www.merriam-webster.com/medical.) On [DATE] at 9:19 AM, an interview was conducted with the ED and the Director of Nursing (DON). The DON stated that the facility's process for an unresponsive resident included checking the code status. If the resident is a full code, staff should initiate CPR, and call 911. The DON stated that a different staff member would be designated to call the physician, family, and 911. The DON said that CPR by the facility staff would be stopped on arrival of the Emergency Medical services (EMS), or if the resident shows signs of life, or if directed by the physician. The DON stated that she received notification regarding resident #1 on [DATE] at 5 AM. She said that a voice message was left by LPN B, stating resident #1 had expired. The DON stated she reviewed the resident's clinical records remotely, and had some questions regarding the actions LPN A took. The DON said she called LPN A for additional information and an explanation of her actions. She asked LPN A who she notified, and if she activated a Code Blue. The DON said that LPN A described bruising to the (body) area the resident was lying on and there was some blood from his nose and his [MEDICAL TREATMENT] fistula. She also reported, that the resident had no heart rate, no respiratory rate, and that CPR was not warranted according to the facility's CPR policy. The ED stated that the facility initiated an investigation on [DATE]. They needed to verify why CPR was not initiated. The ED said that the timeframes documented by LPN A were questionable as they were too precise. The ED stated that LPN A explained, that at the beginning of her shift, resident #1's vital signs were within normal limits. He was responsive at 1 AM, with no sign or symptom of distress. At approximately 2:30 AM, the nurse reported she went in to further monitor the resident and found him unresponsive. He had bruising where his back met the bed. Code Blue was not called and CPR was not initiated. The DON stated a Code Blue was not called by LPN A to alert staff to come to resident #1's room. The DON said LPN A made an independent decision not to initiate CPR based on the facility's CPR during COVID-19 Pandemic policy and procedure. A further interview with the DON on [DATE] at 10:51 AM revealed that she was not sure why the night supervisor did not investigate, or go to resident #1's room when she was informed of his death. The DON verbalized that she educated LPN B on her responsibilities. The DON stated that Registered Nurses (RN) in the facility at the time of the incident were not made aware of the resident's

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) condition/expiration, since a Code Blue was not called. On [DATE] at 11:40 AM, LPN A stated that on [DATE], around midnight, she monitored resident #1's vital signs and they were stable. She found him in bed leaning towards one side and asked the certified nursing assistant (CNA) for assistance to reposition the resident. LPN A stated that at approximately 1 AM, resident #1 had his face covered with his blanket. She uncovered his face, opened his eyes and said he was okay. At 2:30 AM, LPN A said the resident's face was again covered with his blanket. She uncovered him, and he did not respond. He did not open his eyes, he did not have a pulse, no respiration, and no blood pressure. The resident had bluish-reddish bruises on his left side. LPN A did not explain why she checked the resident's back while monitoring the resident's response. LPN A stated, that due to the data she collected at that time, she decided not to start CPR. LPN A stated she had seen residents like that before, and her CPR educational classes said one reason not to do CPR, was if the resident showed signs and symptoms of clinical death. LPN A stated she called the night supervisor, LPN B approximately half an hour after observing the resident and explained her findings. LPN A did not explain why she waited half a half hour before notifying the night supervisor, LPN B. She verbalized that LPN B asked her what the resident's code status was, and she responded, I don't know. LPN B directed her to call the physician, family, and the funeral home. LPN A stated that the night supervisor did not come to the COVID unit to observe resident #1. LPN A did not explain why she did not call any of the three RNs who were working in the facility at the time. LPN A stated, that since she was on the COVID unit, and knew her clinical data, she felt it was not necessary for a nurse to come into the COVID unit and then return to the non-COVID units. LPN A stated that she did not document her observations, the clinical signs and symptoms of death, and her reason for not initiating CPR for resident #1 as she was in a rush, thinking of something else. The witness statement from CNA D dated [DATE] revealed that resident #1 was repositioned multiple times during the shift. Documentation read, around 2:30 am, the nurse on shift notified me that the patient (name) was unresponsive, so we checked the pulse which was absent. Then she notified the supervisor. At this point I was notified by the nurse to 'clean the patient'. I followed orders and provided the patient care. On [DATE] at 1:29 PM an interview was conducted with the ED, the DON and LPN B. LPN B stated she was the night supervisor on the 11:00 PM-7:00 AM shift on [DATE] to [DATE]. She stated that on [DATE] at approximately 3 AM, she received a call from LPN A who informed her that resident #1 had expired. LPN B stated that LPN A mentioned that the resident was found unresponsive with no pulse or heart rate. LPN A reported that there was bruising to the left side of the resident's body and the resident was showing no signs of life. LPN B stated that she did not observe the resident as LPN A was competent. She said she directed LPN A to call the physician and notify the resident's family. LPN B stated that she did not go to resident #1's room to assess him as she was worried about going into the COVID unit and then returning to other units with healthy residents. LPN B stated that prior to COVID 19, she would have checked on the resident and followed the facility's policy. LPN B stated that she did not document her interaction with LPN A. On [DATE] at 9:15 AM, the DON stated that LPNs monitor and observe residents, while RNs assess residents. She said the expectation was that LPN A should have called the RN to assess the resident prior to her decision to withhold CPR. She added that it would have been best practice for LPN B to consult with the RNs on duty to assess the resident. On [DATE] at 10:15 AM, the Medical Director (MD) stated she saw resident #1 the day before he expired. The MD stated that LPN A should have called the registered nurse (RN) to assess the resident prior to making the final decision to withhold CPR. The MD said there was a need to re-educate the staff. She added that LPN A should have called the RN on duty when resident #1 was found unresponsive. The MD stated she did not know why this was not done. The Facility Assessment completed on [DATE] and last reviewed on [DATE] indicated that training topics would include, Resident's rights and facility responsibilities-ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents. Review of the Job description for Licensed Practical Nurse showed that LPN charge nurses should, Ensure that nursing services personnel are giving proper resident care and performing their respective duties in accordance with written policies, procedures and manuals .Know and comply with and ensure that all nursing services personnel know and comply with Residents' Rights rules; Monitor nursing services to ensure that residents' rights and needs are met Review of the corrective measures implemented by the facility starting on [DATE] revealed the following: -An Ad Hoc Quality Assurance and Performance Improvement (QAPI) was conducted on [DATE], and a Four-point Action plan was developed. -The Agency for Healthcare Administration (AHCA-state survey agency) Immediate report was submitted on [DATE]. -LPN A was suspended pending investigation, and witness statements were obtained from LPN A, and LPN B on [DATE]. -Nursing administration team initiated staff education on the CPR Policy, Advance Directive Policy, and conducted Code Blue Quality Assurance Drills, detailed documentation, two nurse's verification of clinical findings initiated on all licensed nurses starting on [DATE]. -As of [DATE] thirty-three of forty licensed nurses had been educated, and post tests conducted. The remaining staff will not be permitted to work until all in-service education on resident code status was complete. -CNAs assigned to resident #1 were interviewed on [DATE] and [DATE]. -[DATE] full house Advance Directive audit was conducted by the ED and DON -[DATE] CPR certification audit completed by the ED and Human Resource (HR) -[DATE] Code Blue drills/competencies were conducted every shift starting with the ,[DATE]PM shift. Previously, the drills were monthly. -On [DATE] department heads, therapy, housekeeping, and dietary staff educated regarding CPR and AD policies. -On [DATE], a second ad hoc QAPI was held including record review with the Medical director. Plan of care was deemed appropriate by MD and IDT determined POC was carried out. CPR would not be performed when obvious signs of clinical death are present per CPR policy and AHA guidelines. Verification by two clinical nurses and documentation noted as areas for improvement. -On [DATE] Code Blue drills/competencies continued. On [DATE] Code Blue drills/competencies continued. New Hire Orientation conducted, included extra training on CPR policy and AD, post-test completed by new hires. The Code Blue drills/competencies were reviewed, and showed they were conducted every shift. -On [DATE] at 1:29 PM the Executive Director and DON revealed, that based on their investigation, the facility determined the root cause analysis was that LPN A made an independent decision not to initiate CPR for resident #1 when he was found unresponsive, based on her clinical judgement. The ED stated that there should have been verification by another nurse, of what LPN A saw. -Staff interviews conducted with 18 staff members on [DATE] between 6:30 AM to 3:35 PM (4 RNs, 4 LPNs, and 10 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 electronic health record, and the first page of the paper medical chart. The nurses stated that they received CPR/DNRO/Code status training upon hire and re-education since [DATE]. -The sample was expanded to include all resident deaths in the facility for the period [DATE] to current. Clinical record reviews showed the resident rights regarding CPR/code status was honored, except in the case of resident #1. -Medical record review was conducted for one current resident. The resident's code status was quickly found in the health record.