STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106025	A. BUILDING _____ B. WING _____	**06/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SARASOTA	**8104 TUTTLE AVE SARASOTA, FL 34243**

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 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 staff interviews, record review, policies review, and review of Emergency Medical Services (EMS) run reports, the facility neglected two residents by failing to provide the required structures and processes to honor their advance directives for cardiopulmonary resuscitation (CPR). Resident #1 and Resident #2 experienced critical changes of condition on [DATE] and [DATE] respectively, each requiring immediate CPR in accordance with their advance directives and facility policy and procedure. The nursing staff assigned to the residents' care failed to ensure timely confirmation of code status and immediate initiation of CPR. Due to improper sequencing and delegation in accordance with facility policy and procedure and American Heart Association (AHA) standards for emergent CPR performance, there was a 12-minute delay in initiation of CPR for Resident #2 and a 23-minute delay in initiation of CPR for Resident #1. The facility failed to ensure that residents received the services necessary to avoid physical harm and failed to ensure that structures to include an effective training and evaluation program and oversight and monitoring of staff performance and credentials were in place. The facility failed to ensure that processes to include ongoing monitoring and supervision of staff's delivery and implementation of care, correct response to a medical emergency, and integration of facility-created tools to ensure accurate documentation of critical events were in place. As a result of the neglect, Resident #1 and Resident #2 did not receive immediate CPR in accordance with their wishes when they were discovered by staff without pulse or respiration. This failure resulted in findings of Immediate Jeopardy, which was removed on [DATE] and reduced to a scope and severity of D. Findings included: A review of the facility policy, Protection of Residents: Reducing the Threat of Abuse & Neglect, revised [DATE], reviewed [DATE] revealed the following: Position Statement & Guidelines .Each resident has the right to be free from abuse, neglect .of any type by anyone .It is the policy and practice of this facility that all residents will be protected from all types of abuse, neglect . Definitions .Neglect - means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. The AHA defines CPR as an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances of survival after [MEDICAL CONDITION]. (https://cpr.heart.org/en/resources/what-is-cpr). The Association highlights the following as critical to life-sustaining outcome: Begin chest compressions as quickly as possible after recognition of [MEDICAL CONDITION] .Trained rescuers are encouraged to perform some steps simultaneously (e.g. checking for breathing and pulse at the same time) in an effort to reduce the time to first compressions. Integrated teams of highly trained rescuers may use a choreographed approach that accomplishes multiple steps and assessments simultaneously rather than in the sequential manner used by individual rescuers. (https://eccguidelines.heart.org/circulation/cpr-ecc-guidelines/part-5-adult-basic-life-support-and-cardiopulmonary-resuscitation-quality/) The basic life support sequence outlined by the AHA for healthcare providers comprises the following order of actions: 1. Ensure scene safety. 2. Check for response 3. Shout for nearby help/activate the resuscitation team; can activate the resuscitation team at this time or after checking breathing and pulse. 4. Check for no breathing or only gasping and check pulse (ideally simultaneously). If no breathing (or only gasping) and no pulse immediately begin CPR. 5. Answer dispatcher's (EMS dispatcher) questions. 6. When the second rescuer arrives, provide 2-person CPR and use AED (automated external defibrillator)/defibrillator. (https://eccguidelines.heart.org/tables/2015-basic-life-support-sequence/) According to their published consensus statement endorsed by the American College of Emergency Physicians and the Society of Critical Care Medicine, the AHA states that Poor-quality CPR should be considered a preventable harm. (https://www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e d8654) The facility policy titled, Cardiopulmonary Resuscitation (CPR) Guidelines, revised [DATE] revealed the following: Purpose .To ensure that each facility is able to and does provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physicians orders, such as DNRs (do not resuscitate orders), and the resident ' s advance directives. Federal Regulations .F678 .Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident ' s advance directives .The AHA urges all potential rescuers to initiate CPR unless: A valid Do Not Resuscitate (DNR) order is in place; Obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; Initiating CPR could cause injury or peril to the rescuer .If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services, in accordance with the resident ' s advance directives and any related physician order, such as code status . Definitions . 'Cardiopulmonary resuscitation (CPR)' refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased . 'Code Status' refers to the level of medical interventions a person wishes to have started if their heart or breathing stops. Policy .CPR Certification .Staff must maintain current CPR certification for Healthcare Providers .Facility must address the provision of basic life support and CPR, including: .Directing staff to initiate CPR when cardiac or respiratory arrest occurs for residents who do not show obvious clinical signs of irreversible death and: .Who have requested CPR in their advanced directives .Facilities must have systems in place to ensure there is the number of staff present at all times per state guidelines who are properly trained and/or certified in CPR for Healthcare Providers to be able to provide CPR until emergency medical services arrives. Within the procedures section of the facility policy titled, Cardiopulmonary Resuscitation (CPR) Guidelines, reference is made to procedure resources by a clinical education resource vendor for CPR one-person rescue and CPR two-person rescue. It is documented that, This facility will utilize the following (clinical education resource vendor) Procedures. A review of the procedures revealed that both included the following: Introduction .Studies show that early CPR can improve a patient ' s likelihood of survival .To prevent a delay in chest compressions, the AHA changed the sequence of CPR .to C-A-B (compressions, airway, and breathing), which gives the highest priority to chest compressions when resuscitating a patient in [MEDICAL CONDITION]. Implementation .The AHA created .a step-by-step guide for CPR .Put on gloves and other personal protective equipment, as needed and available .Verify the safety of the environment .Assess whether the patient is unresponsive by tapping the patient on the shoulder and shouting, 'Are you all right?' .If the patient is unresponsive, shout for help and activate the emergency response system via mobile device (if appropriate) .Check to see whether the patient is apneic or only gasping .and, if you're able, simultaneously check for a

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) pulse to minimize delay in detecting [MEDICAL CONDITION] and initiating CPR . Documentation .Document all of the events of resuscitation and the names of the individuals present. Record the reason CPR was initiated, whether the patient suffered from cardiac or respiratory arrest, the location where the arrest occurred, whether any witnesses were present, the time CPR began, and the duration of CPR. Note the patient's response, any complications, and any interventions you took to correct complications. If the patient also received ACLS (advanced cardiac life support) measures, document the interventions performed, the person who performed them and when, the equipment used, and the results. A review of the facility document titled, LPN Unit Licensed Practical Nurse (LPN) Job Description Primary, revision date [DATE] revealed the following: The LPN Unit Licensed Practical Nurse delivers quality nursing care to patients through interpersonal contact and provides care and services to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient in accordance with all applicable laws, regulations, and Life Care standards .Reports to Director of Nursing (DON) or other nursing supervisor .Must have CPR certification upon hire or obtain during orientation. CPR certification must remain current during employment .Must possess the ability to make independent decisions when circumstances warrant such action .Must be knowledgeable of nursing practices and procedures as well as the laws, regulations, and guidelines governing nursing functions in the post-acute care facility .Must have the ability to implement and interpret the programs, goals, objectives, policies, and procedures of the nursing department .Must understand and follow company policies .Must be able to assign duties, instruct, and provide clinical supervision to CNAs .Must be able to chart appropriately and timely . 1. A review of the documentation in the medical record for Resident #1 revealed an Event Note dated [DATE] 12:45 a.m. entered and e-signed by Staff B, Licensed Practical Nurse (LPN). The note read: CNA (Certified Nursing Assistant) came to nurse at 12:45 a.m. to report that resident have passed. Pulled chart, she was a Full Code. Called medical emergency over intercom. Retrieved crash cart. CPR was started by (Staff C, RN/Staff A, CNA). CNA (Staff A) managed ambu bag (manual resuscitator). Nurse (Staff D, LPN) called 911 and printed paperwork for EMTs (Emergency Medical Technicians). They arrived and worked on resident until 1:30 a.m. and pronounced her deceased . Called DON (Director of Nursing) to give report and to check to see if we can call (funeral home). She said yes, contacted them at 2 a.m. and they arrived at 3:30 a.m. Tried to contact daughter at 1:45 a.m., left message to call facility, and gave our number. No return call as of 7:15 a.m. An Alert Note dated [DATE] 12:45 a.m. was entered following the event note, also authored and e-signed by Staff B. The note read: CNA came to nurse to report at 12:45 a.m., that the resident may have passed. Pulled chart and resident was a full code. Called medical emergency to room . over the intercom. Retrieved the crash cart. CPR was started by Nurse (Staff C)/Nurse (Staff B) and ambu bag was performed by CNA (Staff A) until EMT arrived at 1:10 a.m. Nurse (Staff D) called 911 and printed paperwork for EMTs. EMTs called resident as deceased at 1:30 a.m. Contacted DON (name) to report and to get the OK (okay) to call (funeral home). Called (funeral home) around 2 a.m. Stated they would be here in an hour and a half. Tried to contact daughter (name) at 1:45 a.m, left message on voicemail to call ., gave nurse's name and facility's phone #. An Event Note dated [DATE] 1:30 a.m. authored and e-signed by Staff B revealed, Resident was pronounced decease at 1:30am by paramedics. The document titled Weights and Vitals Summary revealed last entry of vitals prior to event was entered on [DATE] at 10:12 a.m.: blood pressure ,[DATE]; temperature 97.7 degrees Fahrenheit; pulse 78 beats per minute; respiration rate 20 breaths per minutes; Oxygen saturation 95% with oxygen via nasal cannula (liters not documented). An interview conducted on [DATE] at 3:00 a.m. with Staff C revealed she was aware of Resident #1 and the incident that occurred on [DATE]. When asked to provide a timeline of the incident, Staff C said, I was on another unit (Manatee Unit) and I was called over by (Staff B) who was caring for the resident, who was on the isolation unit (Ringling Unit). (Staff B) wanted me to pronounce the patient as deceased because I'm an RN and she is an LPN. She called me on the phone and asked me to come over and pronounce the patient being that I was the RN in the building at the time. So, I said sure and I verified that (Resident #1) had expired. (Staff B) did not call me to verify a code. (Staff B) said something about how she hadn ' t checked (Resident #1's) code status. She asked me if I would start the code while she got the other stuff rolling and made calls. I said sure. I made sure she overhead paged medical emergency. Someone went and got the AED (Automated External Defibrillator), (and) someone else got the crash cart. I started compressions before they brought the backboard. (Resident #1) was not breathing and no heartbeat. When asked how Resident #1 felt when verifying vitals, Staff C said, She's not the coldest person I've ever touched, (Resident #1) was not in rigor. When asked who verified Resident #1's code status. Staff C said, Both of us went out to the desk and checked it and that ' s when she asked me to start the code. I have no idea how much time elapsed from when (Resident #1) was found to when CPR was started, (Staff B) gave me no indication of time. I did not tell administration about the incident because (Staff B) told me she called the DON; I don't know what she told them. (Staff B) and I switched off a few times in CPR before Emergency Medical Services (EMS) got there. We performed max ,[DATE] minutes, maybe 3 switches every 50 compressions. Once EMS arrived around 1:10 a.m. I backed off and EMS performed CPR for about 20 minutes. Staff C confirmed that in Long-Term Care, the procedure when a resident was found unresponsive was to ascertain the code status if it was not already known, and if the patient was a full code then immediately start CPR. Staff C said, I don't believe (Staff B) checked the code status before she called me .but again, I was called to pronounce death. On [DATE] at 3:24 a.m., the DON and the Administrator were asked to join the interview with Staff C. Staff C was asked to repeat the incident to administration. Staff C said, I was called over to pronounce the death of (Resident #1) by (Staff B) and I came over and ascertained patient wasn't breathing, no heartbeat, and I said yep you're right she's passed. I became aware that (Staff B) wasn't sure of (Resident #1's) code status and we went to check. (Resident #1) was a full code. (Staff B) asked me if I could start CPR and I told her she needed to call the DON. (Staff B) overhead paged medical emergency, others arrived, not sure all who, we started a code, I did compressions, the AED arrived. I can't tell you the exact number of compression rounds, but I'm thinking in the neighborhood of 3 switches between (Staff B) and I before EMS arrived. The Administrator and DON were asked if any of this information regarding the possible delay in critical CPR had been shared with them. The DON said, Nothing was shared with me about the checking of the code status. The death itself was reported to me but nothing other than that. The DON confirmed it was a facility requirement for an LPN and an RN to check a resident's code status. The DON continued saying, The expectation for incident documentation is document in the chart. I try and get a timeline of the day before (an incident) and how the resident was doing. The DON confirmed that documentation was required in a progress note which should include the last assessment and resident status, but no other specific data points. She stated that there was a sheet on the crash cart for timeline documentation. An interview conducted on [DATE] at 4:25 p.m. with the Physician Assistant (PA) to Resident #1's assigned Medical Doctor (MD) revealed that the PA recalled Resident #1. The PA was provided a copy of Resident #1's medical chart to assist with recall of information. The PA confirmed the resident ' s age and medical diagnosis. The PA said, She was coming to the facility for rehab. She was not being admitted for long term care at the time. It seems that she was living at home with caregivers and neighbors helped as well. She was doing physical therapy. She was a poor historian. She did not have a [DIAGNOSES REDACTED]. She wanted to be a full code. She had chest pain and was sent to the emergency room (ER) for an evaluation. The ER physician did not find anything acutely wrong with her. She came back with no change of plan that same day. Over the next few days she did not have a change of condition. It would not be unusual for a resident at this age to have a sudden change of condition. I do not recall who I was called by the night of the incident, but I was called late at night. I was told patient was found non-responsive, EMS (Emergency Medical Services) was called, she was pronounced deceased . I do not recall who called me. After the death, the MD signed a death certificate stating that it was likely acute [MEDICAL CONDITION] infraction. She did have a left leg laceration . I wasn't surprised she had an acute event; my impression was that this was an acute event. Apparently, they called the daughter and the daughter was working on deeming (Resident #1) incapacitated and considering a DNR. And when the nurse interviewed (Resident #1), the resident was able to express that she wanted to be a Full Code. She was what I would expect for someone of 100, declining. When they come here, hopefully we can rehab them. She had a history of [REDACTED]. In my experience less than 1% of people recover after being found without a pulse. In fact, I don ' t think I've seen anyone walk out of the hospital after being provided with CPR, especially at that age. In this case I don't think the outcome would have changed at all. The PA reported that it was absolutely the expectation to perform the advanced directive order in place for a resident regardless of age. Further review of the medical record for Resident #1 revealed that she was admitted to the facility on [DATE] for rehabilitation. [DIAGNOSES REDACTED].#1 revealed that Provide CPR was selected in response to the line item, Please indicate your wishes regarding .Cardiopulmonary Resuscitation (CPR). A review of the active physician orders revealed an order for [REDACTED].Resident's Advance Directives will be honored. A progress note titled, Admission/Readmission Note dated [DATE] at 10:50 a.m. authored and e-signed by the Social Services Assistant revealed the following: Resident #1 was admitted to (facility) on [DATE] from (acute care hospital) with a dx (diagnosis) of arterial insufficiency and R (right) foot

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) gangrene. Full code status has been elected. SW (Social Worker) spoke with (Resident #1's) daughter, (name), as per (Resident #1). (Daughter) states prior to hospitalization , (Resident #1) was living at home alone and used a walker to ambulate. (Resident #1) did have some assistance from her neighbor and a private duty who would help (Resident #1) with shopping and cleaning. A telephone interview conducted on [DATE] at 3:14 p.m. with Resident #1's daughter revealed that the reason Resident #1 originally went to the facility was because her toes were turning black. The daughter said, She was very good. The foot doctor recommended we take her to the cardiologist. He performed surgery on her leg to get circulation down to her toes again. And he told me the surgery went well . I got very little information from that place (referring to the facility) and I spoke to a nurse, and she told me my mom seems to be okay but I was not able to speak to her because she was very hard of hearing and so there was no sense of me talking to her on the phone. I was told not to hurry coming down because I could not visit her at the hospital or facility. And that was it. When asked to provide a timeline of events on [DATE] as provided to her by the facility, Resident #1 ' s daughter said, I got a call about 1:45 a.m. but my phone was off. The next morning when I got the message and called back, I was told they tried to do CPR and revive her, but she passed and that is all I know. The last time I spoke to her was at the hospital. The hospital was able to arrange for me to speak with her. She wasn't quite coherent anymore, she kept saying come and visit me and I tried to explain I couldn't because of [MEDICAL CONDITION]. When asked if the facility notified her regarding her mother going to the hospital with chest pain on [DATE], the daughter said, No. I wasn't notified. I didn't know they sent her back to the hospital. No one told me that. I had trouble getting through to the facility. I was told the nurse was busy now, the nurse was handing out medication, and the nurse would call me back. Then I got a text message saying, 'Oh, we had a wonderful day today, all the seniors were playing bingo' and I thought that's not right. There is no way my mom is playing bingo. She's lucky she knows how to open the TV. I had pretty much everything taken care of when she lived at home. We talked every day. She was okay until all this stuff started with her foot. I thought she was doing good. When asked if someone from the facility ever reached out to discuss Resident #1's wishes regarding admissions and care, her daughter said, No nothing pertaining to my mom except for the one time. It was someone from the facility. They told me that she was all right, she was taking her medication. But that's it, very little information. They left a message on my phone that she passed. And when I called back, they answered. I said I'm calling about my mother. And they told me that they tried to do CPR and that they had 911 coming in. They released the body to a funeral home, and I explained to the funeral director that her body must be picked up by cremation. The funeral home told me I owed them money. When asked if the facility waited for directions regarding releasing Resident #1's body, the daughter said, No, they really couldn't since it was in the middle of the night and my phone was off. At least we got to celebrate her [AGE] year-old birthday before all this started. Everyone was there. It is a really great memory to have. It's just so sad how after all this COVID-19, all these people are dying without anyone with them. An interview on [DATE] at 5:50 p.m. with Staff B revealed that she had worked in the facility for 2 years and 3 months. At the time of interview, Staff B acknowledged that her Basic Life Support (BLS) CPR card expired in [DATE]. Staff B said, I didn't know when we would be renewing it because I didn't notice renewal was posted on the back board. Staff B indicated that she recalled Resident #1, and the night of Resident #1's expiration. Staff B said, My shift started at 11:00 p.m., and I had not worked on Ringling in quite a while. The night of [DATE] was the first night I cared for the resident. Staff B provided a timeline of the incident involving Resident #1. Staff B said, Well, I can give you approximate times. About 12:45 a.m., the CNA (Staff A) came out and said she thought Resident #1 passed. I went into the room, checked the pulse, breathing, and Resident #1 had neither. I called the RN on Manatee, (Staff C), and told her I had a patient that expired and asked her to come over and verify it, and she came right away. I had just pulled the chart out when (Staff C) came over. I did not go into the room with (Staff C) because I was pulling the chart to check if (Resident #1) was a full code or DNR. (Staff C) came over within a couple minutes and went into the room. I had just got the chart out. I realized she was a full code. I said Resident #1 was a full code and (Staff C and Staff A) went back into the resident's room to begin CPR. I got the crash cart. I put the board underneath Resident #1's back and set up the ambu bag for the CNA. Before I got the crash cart, I called medical emergency over the intercom twice. I went back out to call 911, but (Staff D) was already making the call for me. I asked her to print out papers because the EMTs always want the orders and face sheet. I went back in. (Staff C) and I switched off about 3 times in CPR. One of the other CNAs had to go over to Manatee to get the AED and brought it back over. (Staff C) set it up and we probably switched off 5 or 6 times. The EMTs showed up about 1:10 a.m. Referring to what time the facility began CPR, Staff B said, (Staff C) walked in right after I started calling medical emergency, so we probably started it about 12:50 a.m. and went until 1:10 a.m. when they (EMTs) arrived. We switched off about 2 or 3 times, so we did it for about 20 minutes. The EMTs worked on (Resident #1) for about 20 minutes and then pronounced her deceased at 1:30 a.m. I can only estimate when CPR was started after the resident was found. I called medical emergency about 5 minutes after the aide reported it to me. (Staff A) went in with me to check on the resident. (Staff C) came over and went into the room as I was pulling the chart. (Staff C) came out of the room because I told her I was checking the chart. I called medical emergency about 5 minutes after (Staff A) reported it to me, so CPR was started about 5 to 6 minutes after (Resident #1) was discovered unresponsive. I called the DON and told her about the death. I tried to call (Resident #1's) daughter but she didn't answer, and I left a message. She never did call back. The funeral home picked up (Resident #1) about 3:30 a.m. The DON told me to leave a note about everything under the door for her to review. A note about what happened, but she was already there so I just gave it to her. Most of the other codes I was involved in were DNR. There was a gentleman (Resident #2) who was a full code that passed about ,[DATE] months ago. (Staff C) performed most of the CPR that time because I was making phone calls. I thought that everything had gone smoothly, like riding a bike. We got education on the code sheet today, but I had not known about the code sheet prior to today so no form was filled out for (Resident #1). The EMS run report (documentation of response to a medical emergency from time the call was received through completion) was reviewed for Resident #1 dated [DATE] and revealed the following: call received 01:09:46; on scene 01:20:18; unwitnessed cardiac (presumed) arrest prior to EMS arrival; CPR initiated by Healthcare professional (Non-EMS); time 1st CPR 01:08; estimated time from collapse to CPR 15 minutes; 100 yo (year old) female was found laying supine in bed at this location (nursing home) .CPR is in progress by FD (Fire Department) prior to EMS arrival on Scene. FD states staff called 911 after they found patient unresponsive and then started CPR on scene (unknown downtime; arrest not witnessed by staff and have no last time seen). FD states patient's core felt warm so they initiated efforts. Staff states patient is full code. A review of Resident #1's clinical record revealed a progress note indicating that the nurse was notified at 12:45 a.m. by the CNA that the resident may have passed. This 12:45 a.m. notification time of change in condition for Resident #1 was also stated by Staff B during her interview on [DATE] at 5:50 p.m. If the resident was initially found at 12:45 a.m., as indicated in the clinical record and staff interview, and CPR was first delivered by the facility staff at 1:08 a.m., as indicated on the EMS run report, an elapsed timeframe of 23 minutes occurred from the time Resident #1 was found unresponsive and the initiation of CPR occurred for Resident #1. During the course of this investigation, additional information was received on [DATE] indicating that another resident also experienced a delay in CPR a few months ago also involving Staff B. A review of facility records and an interview with Staff B on [DATE] at 5:50 p.m. led to the identification of Resident #2. 2. A review of the documentation in the medical record for Resident #2 revealed a Health Status Note within the nursing progress notes with an effective date of [DATE] 7:00 a.m. The author was recorded as Staff B. The note read: Resident was deceased at 5:30 a.m. CNA called nurse to room to let her know that resident was non-responsive at 4:40 a.m. Checked chart and resident was Full Code. Nurse called Medical emergency over intercom. Nurse associates started CPR on resident. Called 911, called DON and called wife. EMT (Emergency Medical Technician) arrived and continued to perform CPR until 5:30am. Wife came in just as EMT finished. CNA's cleaned resident up. Wife called (funeral home). They arrived at 7:55 a.m. The last nursing progress note entered prior to the resident's change in condition containing any resident status data was authored by an RN, effective date [DATE] 10:34 p.m. and revealed the following: VS (vital signs) ,[DATE] HR (heart rate) 122 RR (respiration rate) 20 O2 sat (oxygen saturation) 95% at 4L (liters). Hgb (hemoglobin) 6.8. (name), PA (Physician Assistant) notified. Pt. (patient) states he is comfortable. Will continue to monitor. A review of the document titled, eINTERACT Change in Condition Evaluation, effective date [DATE] 5:11 a.m., electronically signed by Staff C, RN revealed the following: The change in condition, symptoms or signs I am calling about is/are: .[MEDICAL CONDITION] .Respiratory arrest .This started on: [DATE] .Morning .Code Status FULL CODE .Most Recent Blood Pressure XXX,[DATE] .Date: [DATE] 22:40 .Most Recent Pulse .150 .Date: [DATE] 22:40 .Most Recent Respiration .18.0 .Date: [DATE] 22:40 .Most Recent O2 (oxygen) sats (saturation) .97.0% Date: [DATE] 00:46 .Oxygen via Nasal .Date and time of clinician notification: [DATE] 05:00 .Message left with PA (Physician Assistant), EMS (Emergency Medical Services) doing CPR. An interview was conducted on [DATE] at 4:01 p.m. with Staff E, CNA, who remembered

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) Resident #2 and had been the aide that found Resident #2 unresponsive. Staff E said, I go in Resident #2's room and I found him, so I called the nurse. I was doing regular rounds. I knew he was dead because the heart was not beating, and he didn't respond so I called the nurse. I checked (Resident #2) for a pulse and breathing. Staff E confirmed reporting Resident #2 unresponsive to Staff B. Staff E said, (Staff B) called 911, started doing CPR, and called another nurse for help. Staff E confirmed the other nurse was Staff C. Staff E confirmed the following sequence of events after finding Resident #2 unresponsive: first telling the nurse, Staff B; next Staff B going into Resident #2's room and assessing the Resident, then Staff B going back to the nursing desk and calling someone, and finally beginning CPR. A telephone interview was conducted on [DATE] at 9:34 a.m. with Staff C regarding Resident #2. Staff C
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 staff, administrative, and physician interviews, record review, policies review, and family interview, the facility failed to ensure that emergency basic life support was immediately provided, including cardiopulmonary resuscitation (CPR), in accordance with resident advance directives. Facility staff failed to follow timely and appropriate initiation of CPR according to facility policy, procedures, and professional standards of quality related to CPR in accordance with the documented wishes for CPR for two (Resident #1 and Resident #2) of 13 sampled residents. On [DATE], Resident #1, a [AGE] year-old female, was assessed to be unresponsive with a significant change in condition. The assigned licensed nurse (Staff B) failed to confirm Resident #1's accurate code status, resulting in delayed initiation of critical life-supporting CPR. Resident #1's care plan, and signed advanced directives, indicated a full-code status. Investigation of Resident #1's change in condition led to the discovery of Resident #2, who was a full code assigned to Staff B. On [DATE], Resident #2, a [AGE] year-old male, was assessed to be unresponsive with a significant change in condition. The facility staff failed to immediately initiate CPR after verification of Resident #2's code status in accordance with the facility's policy and procedures related to CPR. The facility's failure to provide immediate CPR for Resident #1 and Resident #2 revealed a system-wide failure. This failure resulted in findings of Immediate Jeopardy, which was removed on [DATE] and reduced to a scope and severity of D. Findings included: A record review of Resident #1's Alert Note in progress notes, dated on [DATE] at 12:45 a.m. by Licensed Practical Nurse (LPN)/Staff B, revealed, CNA (Certified Nursing Assistant) came to nurse to report at 12 45am, that the resident may have passed. Pulled chart and resident was a full code. Called medical emergency to (Resident #1's room) over the intercom. Retrieved the crash cart. CPR was started by (Staff C, Registered Nurse (RN)/Staff B, Licensed Practical Nurse (LPN)) and ambu bag (Bag Valve Mask used for resuscitation) was performed by (Staff A, CNA) until EMT (Emergency Medical Team) arrived at 1:10am. (Staff D, LPN) called 911 and printed paperwork for EMTs. EMTs called resident as deceased at 1:30am. Contacted DON (Director of Nursing) to report and to get ok to call (funeral home). Called (funeral home) around 2am. Stated they would be here in an hour and a half. Tried to contact Daughter at 1:45 a.m., left message on voicemail to call facility, gave nurse's name and facility's phone number. An interview on [DATE] at 3:00 a.m. with Staff C/RN revealed she was aware of Resident #1, and the incident that occurred on [DATE]. Staff C said, I was on another unit (Manatee Unit) and I was called over by (Staff B) who was caring for the resident, who was on the isolation unit (Ringling Unit). (Staff B/LPN) wanted me to pronounce the patient as deceased because I'm an RN and she is an LPN. She called me on the phone and asked me to come over and pronounce the patient being that I was the RN in the building at the time. So, I said sure and I verified that (Resident #1) had expired. (Staff B) did not call me to verify a code. (Staff B) said something about how she hadn't checked (Resident #1)'s code status. She asked me if I would start the code while she got the other stuff rolling and made calls. I said sure. I made sure she overhead paged medical emergency. Someone went and got the AED (Automated External Defibrillator for resuscitation), someone else got the crash cart. I started compressions before they brought the backboard. (Resident #1) was not breathing and no heartbeat . she's (Resident #1) not the coldest person I've ever touched . was not in rigor. Staff C clarified who verified Resident #1's code status. Staff C said, Both of us went out to the desk and checked it and that's when she asked me to start the code. I have no idea how much time elapsed from when (Resident #1) was found to when CPR was started. (Staff B) gave me no indication of time. I did not tell administration about the incident because (Staff B) told me she called the DON; I don't know what she told them. (Staff B) and I switched off a few times in CPR before Emergency Medical Services (EMS) got there. We performed max ,[DATE] minutes, maybe 3 switches every 50 compressions. Once EMS arrived around 1:10 a.m. I backed off and EMS performed CPR for about 20 minutes. Staff C confirmed that in Long-Term Care, the procedure once a resident is found unresponsive was to ascertain the code status if it was not already known, and if the patient was a full code then immediately start CPR. Staff C said, I don't believe (Staff B) checked the code status before she called me .but again, I was called to pronounce death. On [DATE] at 3:24 a.m., the DON and the Administrator joined the interview with Staff C. Staff C repeated the incident to administration. Staff C/RN said, I was called over to pronounce the death of Resident #1 by (Staff B) and I came over and ascertained patient wasn ' t breathing, no heartbeat, and I said yep you're right she's passed. I became aware that (Staff B) wasn't sure of (Resident #1's) code status and we went to check. (Resident #1) was a full code. (Staff B) asked me if I could start CPR, and I told her she needed to call the DON. (Staff B) overhead paged medical emergency, others arrived, not sure all who, we started a code, I did compressions, the AED arrived. I can't tell you the exact number of compression rounds, but I'm thinking about 3 switches between (Staff B) and I before EMS arrived. The DON revealed that Resident #1's death was reported to her; however, no nursing staff reported a delay in checking the resident's code status or a delay in CPR initiation. The DON confirmed it was a requirement for an LPN and an RN to check a resident's code status. The DON continued saying, The expectation for incident documentation is document in the chart. I try and get a timeline of the day before (an incident) and how the resident was doing. The DON confirmed that documentation was required in a progress note which should include the last assessment, and resident status, but no other specific data points. There was a sheet on the crash cart for timeline documentation. A record review of Resident #1's Admission Record revealed an admission date of [DATE], and a discharge date of [DATE], [DIAGNOSES REDACTED]. Further record review of Resident #1's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008), dated [DATE], found the resident ambulated with an assistive device with assistance of one required for transfers. The form also noted that Resident #1 was transferred for rehabilitation and repair of sutures. Resident #1's Resident/Family Education Assessment & Interdisciplinary Flow Record, signed without a date of completion, revealed the anticipated length of stay was equal to or less than one month. The document revealed that Resident #1 had no limitations or barriers to learning, was able to understand basic information, was motivated to learn, and was able to verbalize understanding. A record review of Resident #1's Advanced Directives Discussion Document, dated [DATE], revealed a status of Provide CPR obtained by a facility nurse, signed by both Resident #1 and a Facility Representative. Resident #1's Care Plan, initiated [DATE], revealed a full code status with a goal of honoring the resident's advanced directives. Resident #1's Active physician's orders [REDACTED]. Resident #1's progress notes, dated [DATE], by the Social Services Assistant (SSA), revealed that a full code status has been elected during the admission on [DATE]. The social worker spoke with the resident's daughter per Resident #1's request and gathered personal information. Resident #1 was living at home alone prior to arriving to the facility and received help from a private duty and the neighbor. The progress note stated that Resident #1 used a walker to ambulate. A record review of Psychosocial Note in progress notes, dated [DATE] at 10:07 a.m. by SSA, revealed, Assessment note for unplanned discharge MDS (Minimum Data Set) with ARD (Assessment Reference Date) of [DATE]: Resident #1 was unable to participate in her assessment related to her passing away on [DATE] . She was alert with confusion. Short and long-term memory loss was anticipated. Resident #1 did not seem aware of the reason that she was in a nursing facility. Her decision making was severely impaired. An interview on [DATE] at 4:25 p.m. with the Physician Assistant (PA) assigned to Resident #1 revealed that the PA recalled Resident #1. The PA used Resident #1's medical chart to recall information. The PA confirmed the resident's age and medical diagnosis. The PA said, She was coming to the facility for rehab. She was not being admitted for long term care at the time. It seems that she was living at home with caregivers and neighbors helped as well. She was doing physical therapy. She was a poor historian. She did not have a [DIAGNOSES REDACTED]. She wanted to be a full code. She had chest pain and was sent to the emergency room (ER) for an evaluation. The ER physician did not find anything acutely wrong with her. She came back with no change of plan that same day. Over the next few days she did not have a change of condition. It would not be unusual for a resident at this age to have a sudden change of condition. I do not recall who I was called by the night of the incident, but I was called late at

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	106025	A. BUILDING _____ B. WING _____	06/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SARASOTA	8104 TUTTLE AVE SARASOTA, FL 34243

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) night. I was told patient was found non-responsive, EMS was called, she was pronounced deceased . I do not recall who called me. After the death, the MD signed a death certificate stating that it was likely acute [MEDICAL CONDITION] infraction. She did have a left leg laceration . When the nurse interviewed (Resident #1), the resident was able to express that she wanted to be a Full Code. She was what I would expect for someone of 100, declining. When they come here hopefully, we can rehab them. She had a history of [REDACTED]. In my experience less than 1% of people recover after being found without a pulse. In fact, I don't think I've seen anyone walk out of the hospital after being provided with CPR, especially at that age. In this case, I don ' t think the outcome would have changed at all. The PA reported that it was absolutely the expectation to perform the advanced directive order in place for a resident regardless of their age. An interview on [DATE] at 4:47 p.m. with the Director of Social Services (DSS), revealed that there was a process for advanced directives. The DSS said, So when a patient is admitted , the nurse goes over the advanced directives. It is part of the nursing assessment upon admission. The nurse will have the patient sign if they can. If not, they will have to get a verbal from the family with witnesses. The DSS verified that Resident #1 wanted to be a full code. The DSS continued, That is the procedure. When we look at the chart, we look at the paperwork and make sure it is in line. We have 72 hours to review the documents. We would then care plan what their wishes are, talk with the resident about their wishes. The SSA (Social Services Assistant) worked with (Resident #1). The resident was not very clear, that is what the SSA told me. We care plan it in (the electronic medical record system) what the advanced directives are. Whenever we have a care plan meeting, we then review the code status, or if the resident has a drastic decline we discuss. To my knowledge the resident had a full code in place. We also talk about discharge planning, issues with depression, anxiety, if they need emotional support, if the patient desires us to call the family, we would also do that. I really don't know much about this resident. An interview on [DATE] at 4:52 p.m. with the SSA revealed they recalled Resident #1. The SSA said, Prior to coming here she was living at home alone, independently. This information I got from the daughter. The resident wasn't able to provide too much, but she gave me permission to talk to her daughter. (Resident #1) signed that she wanted to be a full code upon admission. I did not verify information from chart that she wanted to be a full code, my interaction was very brief. This is not a usual situation but when I met with her, she looked like she didn't feel well, and the next time she wanted me to talk to the daughter. I did not verify with the daughter her advanced directives. I just got a social history and living prior to her hospitalization . She was living at home, she was independent, the daughter planned on coming down from New York in about a week or two to figure out a plan for the resident's discharge. First interaction with the resident was a day or two before the [DATE] progress note. That was the date I entered the note, but I met her prior. The SSA confirmed that Resident #1 was a full code. An interview on [DATE] at 5:50 p.m. with Staff B/LPN revealed that she had worked in the facility for 2 years and 3 months. At the time of interview, Staff B acknowledged that her Basic Life Support (BLS) CPR card expired in [DATE]. Staff B said, I didn't know when we would be renewing it because I didn't notice renewal was posted on the back board. Staff B indicated that she recalled Resident #1, and the night of Resident #1's expiration. Staff B said, My shift started at 11:00 p.m., and I had not worked on Ringling in quite a while. The night of [DATE] was the first night I cared for the resident. Staff B provided a timeline of the incident involving Resident #1. Staff B said, Well, I can give you approximate times. About 12:45 a.m., the CNA (Staff A) came out and said she thought Resident #1 passed. I went into the room, checked the pulse, breathing, and Resident #1 had neither. I called the RN on Manatee, (Staff C), and told her I had a patient that expired and asked her to come over and verify it, and she came right away. I had just pulled the chart out when (Staff C) came over. I did not go into the room with (Staff C) because I was pulling the chart to check if (Resident #1) was a full code or DNR. (Staff C) came over within a couple minutes and went into the room. I had just got the chart out. I realized she was a full code. I said Resident #1 was a full code and (Staff C and Staff A) went back into the resident's room to begin CPR. I got the crash cart. I put the board underneath Resident #1's back and set up the ambu bag for the CNA. Before I got the crash cart, I called medical emergency over the intercom twice. I went back out to call 911, but (Staff D/LPN) was already making the call for me. I asked her to print out papers because the EMTs always want the orders and face sheet. I went back in. (Staff C) and I switched off about 3 times in CPR. One of the other CNAs had to go over to Manatee to get the AED and brought it back over. (Staff C) set it up and we probably switched off 5 or 6 times. The EMTs showed up about 1:10 a.m. Referring to what time the facility began CPR, Staff B said, (Staff C) walked in right after I started calling medical emergency, so we probably started it about 12:50 a.m. and went until 1:10 a.m. when they (EMTs) arrived. We switched off about 2 or 3 times, so we did it for about 20 minutes. The EMTs worked on (Resident #1) for about 20 minutes and then pronounced her deceased at 1:30 a.m. I can only estimate when CPR was started after the resident was found. I called medical emergency about 5 minutes after the aide reported it to me. (Staff A/CNA) went in with me to check on the resident. (Staff C) came over and went into the room as I was pulling the chart. (Staff C) came out of the room because I told her I was checking the chart. I called medical emergency about 5 minutes after (Staff A) reported it to me, so CPR was started about 5 to 6 minutes after (Resident #1) was discovered unresponsive. I called the DON and told her about the death. I tried to call (Resident #1's) daughter but she didn't answer, and I left a message. She never did call back. The funeral home picked up (Resident #1) about 3:30 a.m. The DON told me to leave a note about everything under the door for her to review. A note about what happened, but she was already there so I just gave it to her. Most of the other codes I was involved in were DNR. There was a gentleman (Resident #2) who was a full code that passed about ,[DATE] months ago. (Staff C) performed most of the CPR that time because I was making phone calls. I thought that everything had gone smoothly, like riding a bike. We got education on the code sheet today, but I had not known about the code sheet prior to today so no form was filled out for (Resident #1). An interview on [DATE] at 5:05 p.m. with Staff A revealed that she was involved with Resident #1's care and notified Staff B of the change in condition on [DATE]. Staff A said, When I come in on my shift, we get a report from the previous shift. I go check the residents at the beginning of the shift. I provided no care to (Resident #1) prior to the night of expiration. No problems were reported to me about (Resident #1) from the other aide, but I still go in and check on the resident. (Resident #1) was lying in bed by the window, I saw her feet. Then I start getting resident vitals, check on call lights. That night one of the other residents was very confused, so most of the beginning of the shift was spent with them. I got to (Resident #1's) room, which would be my last room in my order of getting vitals, she didn't look okay. I went straight to the nurse. The nursing station is right outside the door .The nurse (Staff B) evaluated Resident #1, called the other nurses, got the crash cart, and CPR was started. I was not in the room when the EMS arrived but prior to that I was. The nurse (Staff B) immediately came into the resident room, then left the room, and then made the announcement over the intercom code blue, which means a medical emergency. I can't say how long we were doing CPR for. An interview on [DATE] at 6:32 p.m. with Staff D, LPN revealed she was on duty the night of [DATE] and recalled Resident #1. Staff D provided a timeline of the event, I was on the University Unit and I heard the overhead page for a code on Ringling. I went and got the AED and brought it to (Resident #1's) room. (Staff B) asked me to call 911 and start the paperwork. (Staff B) made the call overhead. I saw (Staff B and Staff C) in (Resident #1's) room, they were performing CPR. (Staff A) was also in the room, from what I heard (Staff A) was the one who found the resident unresponsive. I was just in the doorway since I wasn't gowned up. I told 911 that the patient was unresponsive, they asked if the patient was breathing, I said yes since they were performing CPR. I told the other aide to wait outside to guide EMS in. I don't really remember times. Staff D indicated that her process when finding an unresponsive resident and determining that they were a full code was to, .Call the code, delegate to my aides about calling 911, get the crash cart. I'm fast, so it would probably take about a minute or two before I started CPR. I just start, I don't call another nurse, I tell the aides to overhead page and get everyone together. I'm an LPN and responsible for initiating CPR. Before starting CPR, I check if they are CPR or DNR in the chart or on the computer. That process should be immediately. Process doesn't take more than a minute or two to check the chart and begin CPR. There should be a staff member documenting time, procedure, and steps before the paramedics come in the nursing notes, like progress notes, time and notifications. Documentation should be a step by step outline. I'm not aware of any other documents that we are supposed to use. I'm not aware of any other documents on the crash cart. An interview on [DATE] at 12:47 p.m. with the DON and the Staff Development Coordinator (SDC)/RN revealed that education and training was provided to staff about what to do during a code situation. The SDC said, I've been in this position since [DATE]. Education and training about code is part of the general orientation that I provide to the nurses, One of the first things I do is to go through the chart in the admissions process, and obtain the resident's wishes about advanced directives (referring to the documentation provided to the resident about code status during the admission process). This is then followed up with a physician order [REDACTED]. These forms to become a full code or DNR are present in the facility for the residents and the nurses. If they find someone unresponsive, no pulse, I go through the process of paging medical emergency overhead. If you are at the nurses' station, grab the chart and go into the

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) room. Instruct the aide to get the chart while the assessment of the resident occurs as soon as possible. Check the code status of the resident under the advanced directives tab of the chart. The SDC confirmed after a resident is assessed, their advanced directive must be verified. If a resident is a DNR, one RN or two LPNS have the capacity to pronounce death. If a resident is full code, CPR must be initiated as fast as possible. The SDC said, An LPN does not need someone to come verify if the resident is a full code or to begin CPR. The SDC revealed that facility procedure is for all nurses to respond to an overhead page for medical emergency. The responding nurses can delegate responsibilities such as retrieving the crash cart, making phone calls, and guiding EMS into the building upon arrival. Additionally, educational mock codes should be performed quarterly. The SDC said, .but it (mock code) has not been provided since [DATE] since we have been focusing on other things like infection control . in [DATE], a code was performed. There were no issues, but we did provide education then. It was just an opportunity to provide education. This was not extended to everyone, not to my knowledge. The SDC revealed that sign-in sheets are kept in her records regarding CPR training. Referring to the employee line list and how an employee ' s education is monitored, SDC said, It is a computer-based learning system. It is a printout of everything that staff member has done. I have two different certification programs. It populates on their work hire date anniversary. The computer program allows you to see what staff training history is. They have a 30-day period from date of anniversary to complete the training. Abuse and neglect training are done at least once a year. During this interview, the DON said, I started in [DATE]; we have not done a mock code since I started I ' m not sure if we have it written anywhere (referring to a step-by-step education plan for CPR), but I can look. I have not trained them on the code sheet. It was not a practice for me, it is now. I don't have evidence personally that staff was trained on it (referring to the code sheet), but it is part of the plan now to clearly document going forward. A follow-up interview with the SDC on [DATE] at 3:00 p.m. revealed that the code incident previously referred to in [DATE] was not an education but rather a post-incident meeting. An interview on [DATE] at 2:12 p.m. with the Medical Director (MD) revealed he met with Resident #1 when the resident was first admitted . The MD said, From what I recall, (Resident #1) was very elderly and complaining of chest pain which I sent her out to the hospital for. The MD confirmed there were no other changes of condition and that the PA notified him when Resident #1 was pronounced deceased . The MD reported that it was absolutely the expectation for facility staff to perform CPR on a resident identified as a full code. The MD confirmed that as a result of the incident involving Resident #1 the facility presented a draft intervention plan to prevent another occurrence. He confirmed he attended the monthly Quality Assurance meetings. The MD said, I will make sure to go over the plan with everyone and make sure they are better educated about everything. A telephone interview on [DATE] at 3:14 p.m. with Resident #1's daughter revealed that the reason Resident #1 originally went to the facility was because her toes were turning black. The daughter said, She was very good. The foot doctor recommended we take her to the cardiologist. He performed surgery on her leg to get circulation down to her toes again, and he told me the surgery went well. The big toe was totally black, and eventually they were thinking of amputating. Before she went to rehab (at the facility), she fell at the hospital. She got stitches in her leg again, and from there they sent her to rehab. They told me she was walking with her walker. I got very little information from that place (referring to the facility) and I spoke to a nurse, and she told me my mom seems to be okay, but I was not able to speak to her because she was very hard of hearing and so there was no sense of me talking to her on the phone. I was told not to hurry coming down because I could not visit her at the hospital or facility and that was it. The daughter provided a timeline of the events as told to her by the facility. The daughter said, I got a call about 1:45 a.m. but my phone was off. The next morning when I got the message and called back, I was told they tried to do CPR and revive her, but she passed and that is all I know. The last time I spoke to her was at the hospital. The hospital was able to arrange for me to speak with her. She wasn't quite coherent anymore, she kept saying come and visit me, and I tried to explain I couldn't because of [MEDICAL CONDITION]. The daughter revealed she had not been notified that Resident #1 went to the hospital while at the facility. The daughter said, No. I wasn't notified. I didn't know they sent her back to the hospital. No one told me that. I had trouble getting through to the facility. I was told the nurse was busy now, the nurse was handing out medication, and the nurse would call me back. Then I got a text message saying, oh, we had a wonderful day today, all the seniors were playing bingo, and I thought that's not right. There is no way my mom is playing bingo. She's lucky she knows how to open the TV. I had pretty much everything taken care of when she lived at home. We talked every day. She was okay until all this stuff started with her foot. I thought she was doing good. Resident #1's daughter revealed she wasn't aware of her mom wanting to be a full code. She stated, I wonder if she even knew what she was signing. The daughter reported that nobody from the facility ever reached out to discuss Resident #1's wishes regarding admissions and care. The daughter stated the facility only reached out one time. They told me that she was all right, she was taking her medication. But that ' s it, very little information. They left a message on my phone that she passed, and when I called back, they answered. I said I'm calling about my mother. And they told me that they tried to do CPR and that they had 911 coming in At least we got to celebrate her [AGE] year-old birthday before all this started. Everyone was there. It is a really great memory to have. It's just so sad how after all this COVID-19, all these people are dying without anyone with them. On [DATE] at 4:48 p.m., the Administrator provided documentation related to the EMS run report. The run report is a record used by the ambulance to record pre-hospital patient care and patient transfer care information when applicable. The Administrator confirmed that the Assistant Director of Nursing (ADON) contacted the County Emergency Services to retrieve Resident #1's information and was the person that documented the information provided. An interview on [DATE] at 4:30 p.m. with the ADON revealed that they contacted EMS on [DATE] at 10:30 a.m. The ADON stated they spoke with an operator who retrieved the run report information from the EMS internal system. The ADON revealed she read the facility documented progress notes recorded by Staff B regarding the timeline of when 911 was called, and EMS arrival time. The ADON verified that the information provided from the EMS system did not match the time of events as reported in the progress notes. Resident #1's Manatee County EMS Patient Care Record (run report) provided directly from the County Emergency Services, dated [DATE], revealed that the Est (estimated) Time Collapse to CPR was 15 minutes. The report documented that the first time CPR was administered by the facility was at 1:08 a.m. EMS received the call from the facility pertaining to a medical emergency at 1:09 a.m. EMS was dispatched at 1:10 a.m. and arrived on scene at 1:20 a.m. EMS was at the patient at 1:21 a.m. and resuscitation was discontinued at 1:35 a.m. due to obvious signs of death. A review of Resident #1's clinical record revealed a progress note indicating that the nurse was notified at 12:45 a.m. by the CNA that the resident may have passed. This 12:45 a.m. notification time of change in condition for Resident #1 was also stated by Staff B during her interview on [DATE] at 5:50 p.m. If the resident was initially found at 12:45 a.m., as indicated in the clinical record and staff interview, and CPR was first delivered by the facility staff at 1:08 a.m., as indicated on the EMS run report, an elapsed timeframe of 23 minutes occurred from the time Resident #1 was found unresponsive and the initiation of CPR occurred. Throughout the course of investigation related to delayed initiation of critical life-supporting CPR for Resident #1 on [DATE], additional information was received on [DATE] indicating that another resident also experienced a delay in CPR a few months prior. A review of facility records and information from the interview with Staff B, which occurred on [DATE] at 5:50 p.m., led to the identification of Resident #2. A record review of Resident #2's Progress Notes, dated [DATE], revealed a Health Status Note by Staff B, LPN. The note stated, Resident was deceased at 5:30 a.m. CNA called nurse to room to let her know that resident was non-responsive at 4:40 a.m. Checked chart and resident was Full Code. Nurse called Medical emergency over intercom. Nurse associates started CPR on resident. Called 911, called DON and called wife. EMT arrived and continued to perform CPR until 5:30 a.m. Wife came in just as EMT finished. CNA's cleaned resident up. Wife called (funeral home). They arrived at 7:55 a.m. A telephone interview on [DATE] at 9:34 a.m. with Staff C/RN regarding Resident #2 revealed she recalled working the night of [DATE] into the morning of [DATE] with some recollection of the night. Staff C confirmed a medical emergency occurred in Resident #2's room. Staff C confirmed involvement in Resident #2's code. Staff C provided a timeline of the incident events. I was in the cardiac unit. (Resident #2) belonged to another unit. Another nurse (Staff B) came to get me and I started CPR as she made the calls. I had the long hall and (Staff B) had the short hall, which included (Resident #2's) room. (Resident #2) was (Staff B's) resident for the night. (Staff B) wanted me to start the code, and she was going to make calls and get things going. I went into (Resident #2's) room to start the code and she made the overhead page for medical emergency. I cannot tell you who else was in the room, any names, or level of licensure they had, or whatever. Staff C did not know why Staff B did not immediately start CPR. Staff C stated, .I believe (Staff B) checked the code status. To my recollection she had already checked the code status prior to me arriving on the scene. I would imagine she coordinated calls to EMS, the doctors, the family, and overhead page medical emergency. I honestly don't have a recollection who was with me performing CPR. I don't recall what time this
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Administer the facility in a manner that enables it to use its resources effectively and**

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	106025	A. BUILDING _____ B. WING _____	**06/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SARASOTA	**8104 TUTTLE AVE SARASOTA, FL 34243**

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) **efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and policies review, the facility administration failed to ensure clinical staff appropriately adhered to facility established policies, procedures, and resident advanced directives related to preforming critical cardiopulmonary resuscitation (CPR) for two (Resident #1 and Resident #2) out of 13 sampled residents. On [DATE] Resident #2, a [AGE] year-old male, was assessed to be unresponsive with a significant change in condition. The assigned licensed nurse (Staff B) failed to immediately initiate CPR after verification of Resident #2's full-code status in accordance with facility's policy and procedures related to CPR. Facility administration failed to monitor, track documentation, provide education, and develop an action plan following the [DATE] event involving Resident #2, which led to a similar sequence of events involving the same assigned staff (Staff B) and a second vulnerable full-code resident, Resident #1. On [DATE], Resident #1, a [AGE] year-old female, was assessed to be unresponsive with a significant change in condition. This change in condition required timely and immediate initiation of critical life-supporting CPR in accordance with Resident #1's care plan and signed advanced directives. The assigned licensed nurse (Staff B) failed to confirm and immediately act upon Resident #1's full-code status, resulting in delayed initiation of critical life-supporting CPR. Resident #1 and Resident #2 were both pronounced deceased by Emergency Medical Services (EMS) following their change in condition. The facility's failure to follow their policies and procedures represented a system wide failure. Failure of the facility staff to ensure that residents expressed wishes related to advanced directives and the right to receive end of life treatment, were honored and protected, resulted in findings of Immediate Jeopardy, which was removed on [DATE] and reduced to a scope and severity of D. Findings Included: 1. A review of the facility document titled, Executive Director (ED) Job Description Primary: Department: Administration, revised date [DATE], revealed, The Executive Director provides leadership and direction for overall facility operations to provide quality patient care in accordance with all laws, regulations, and . standards. Provides oversight of key areas including . human resources . and clinical operations. Implements policies pertaining to patient care, care giving, and support staff . Reports to Regional Vice President. Working Conditions Involved with patients, associates . personnel, etc. under all conditions and circumstances. Attends and participates in continuing education programs. Specific Requirements Must possess the ability to make independent decisions when circumstances warrant such action. Must be knowledgeable of administration practices and procedures as well as the laws, regulations, and guidelines governing administrative functions in the post-acute facility. Must have the ability to implement and interpret the programs, goals, objectives, policies, and procedures of the administration department. Must perform proficiently in all competency areas including but not limited to: daily leadership, responsibilities, supervisory responsibilities . regulatory compliance, patient rights, and safety, and sanitation. Must understand and follow company policies including . compliance procedures. Must ensure patients receive high quality care. Must ensure facility is compliant with all Federal, State, local, and JCAHO (The Joint Commission) requirements as well as serve as the facility's Compliance and Ethics Liaison. Must ensure facility is . safe for the comfort, convenience and safety of patients . Must effectively supervise team. A review of the facility document titled, Director of Nursing (DON) Job Description Primary: Department: Nursing Administration, revised date [DATE], revealed: The Director of Nursing plans, organizes, develops, and directs the overall operation of the Nursing department to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient in accordance with all applicable laws, regulations, and . standards. Reports to Executive Director (ED). Working Conditions Works in department as well as throughout facility. Involved with patients, associates . personnel, etc. under all conditions and circumstances. Specific Requirements: Must be able to communicate effectively with physicians, nursing staff, and all other staff. Liaisons with patients, families, support departments, etc. to adequately plan for patient needs. Must be ale to collect, analyze, and manage data. Must have expert knowledge in field of practice. Must possess the ability to make independent decisions when circumstances warrant such action. Must be knowledgeable of nursing administration practices and procedures as well as the laws, regulations, and guidelines governing nursing administration functions in the post-acute care facility. Must have the ability to implement and interpret the programs, goals, objectives, policies, and procedures of the nursing administration department. Must perform proficiently in all applicable competency areas. Must understand and follow company policies including . compliance procedures. Promotes a culture of integrity and professionalism by adhering to . Code of conduct and completes mandatory Code of Conduct and other appropriate compliance training. Actively implements the compliance program. Must be able to plan, develop, organize, implement, evaluate, establish benchmarks, and direct staff. Must be able to recruit, select, train, evaluate, counsel, and supervise nursing staff. Must be able to assign appropriate level of CNAs and LPNs per shift. Must be able to direct care provided by nursing staff. Must be able to provide direct nursing care as necessary. Must be able to perform functions of a staff nurse as required. Must be able to concentrate and use reasoning skills and good judgement. A review of the facility document titled, RN Staff Development Coordinator (SDC) Job Description Primary, revision date [DATE] revealed the following: The RN Staff Development Coordinator plans, organizes, develops, and directs all in-service education to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient in accordance with all applicable laws, regulations, and Life Care standards .Reports to Director of Nursing (DON) .Plans and participates in continuing education programs .Must have the desire and ability to effectively train and educate all nursing associates and other associates as applicable .Must have expert knowledge in field of practice .Must have the ability to implement and interpret the programs, goals, objectives, policies, and procedures related to facility education and training .Must understand and follow company policies .Must be able to plan, develop, conduct, evaluate, and coordinate staff training, education, in-service, and orientation .Must maintain associate training and in-service records . A review of the facility document titled RN Unit Registered Nurse (RN) Job Description Primary, revision date [DATE] revealed the following: The RN Unit Registered Nurse delivers quality nursing care to patients through interpersonal contact and provides care and services to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being .Reports to Director of Nursing (DON) .Must have CPR certification upon hire or obtain during orientation. CPR certification must remain current during employment .Must be knowledgeable of nursing practices and procedures as well as the laws, regulations, and guidelines governing nursing functions in the post-acute care facility .Must have the ability to implement and interpret the programs, goals, objectives, policies, and procedures of the nursing department .Must understand and follow company policies .Must be able to provide clinical supervision to CNAs (Certified Nursing Assistants) and LPNs (Licensed Practical Nurses) .Must be able to chart appropriately and timely. 2. A review of Resident #2's Admission Record revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Resident #2's Admission/Readmission Collection Tool- V2, dated [DATE], stated, Patient arrived via stretcher. Patient is alert, oriented, and able to verbalize understanding of care. After careful review, patient signed all of the admission paperwork. Patient vital signs are within acceptable limits . Patient's goal is to gain strength to return home. A record review of Resident #2's Minimum Data Set (MDS) 5-day scheduled assessment, dated [DATE], revealed short term and long-term memory were intact. Resident #2 was normally able to recall the current season, location of their room in the facility, orientation to living in a nursing home, and had cognitive skills for daily decision making at an independent level. Active [DIAGNOSES REDACTED]. A record review of Resident #2's Occupational Therapy: OT Evaluation & Plan of Treatment, signed and dated on [DATE] and revised on [DATE], revealed, Patient Goals: To feel better and return home. Potential for Achieving Rehab Goals: Patient demonstrates excellent rehab potential as evidenced by ability to follow multi-step directions, high prior level of function, high-cognitive functioning, motivated to participate and motivated to return to prior level of living. Focus of Plan of Treatment = Restoration. A record review of Resident #2's Advanced Directives Discussion Document, dated [DATE], revealed a status of Provide CPR obtained by a facility nurse, signed by both Resident #2 and a Facility Representative. A review of Resident #2's Care Plan, initiated [DATE], revealed a full code status with a goal of honoring the resident's advanced directives. Resident #2's Physician's Active Orders, dated [DATE], revealed an order for [REDACTED].#2's Social Service Assessment revealed code status was full code, that he had been independent at home using no DME (durable medical equipment), and that he was alert and oriented x 4 (person/place/time/situation). The assessment revealed that the resident had a longtime spouse, and in his retirement had enjoyed reading and volunteering. The assessment reflected that his discharge plan was to return home with his spouse. A record review of Resident #2's vital signs, dated [DATE] at 10:34 p.m., by a Registered Nurse (RN) showed, VS (vital signs) ,[DATE] HR (heart rate) 122 RR (respiration rate) 20 O2 sat

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) (oxygen saturation) 95% at 4L (liters). Hgb (hemoglobin) 6.8. (name), PA (Physician Assistant) notified. Pt. (patient) states he is comfortable. Will continue to monitor. Resident #1's eINTERACT Change in Condition Evaluation, dated [DATE] and electronically signed by Staff C/RN, stated, The change in condition, symptoms or signs I am calling about is/are: .[MEDICAL CONDITION] .Respiratory arrest .This started on: [DATE] .Morning .Code Status FULL CODE .Most Recent Blood Pressure XXX,[DATE] .Date: [DATE] 22:40 .Most Recent Pulse .150 .Date: [DATE] 22:40 .Most Recent Respiration .18.0 .Date: [DATE] 22:40 .Most Recent O2 (oxygen) sats (saturation) .97.0% Date: [DATE] 00:46 .Oxygen via Nasal .Date and time of clinician notification: [DATE] 05:00 .Message left with PA, EMS (Emergency Medical Services) doing CPR. A record review of Resident #2's Progress Notes, dated [DATE], revealed a Health Status Note by Staff B, Licensed Practical Nurse (LPN). The note stated, Resident was deceased at 5:30 am. CNA (Certified Nursing Assistant) called nurse to room to let her know that resident was non-responsive at 4:40am. Checked chart and resident was Full Code. Nurse called Medical emergency over intercom. Nurse associates started CPR on resident. Called 911, called DON and called wife. EMT (Emergency Medical Team) arrived and continued to perform CPR until 5:30 am. Wife came in just as EMT finished. CNA's cleaned resident up. Wife called (funeral home). They arrived at 7:55 am. An interview on [DATE] at 4:01 p.m. with Staff E/CNA revealed she remembered Resident #2. Staff E stated, I go in (Resident #2's) room and I found him, so I called the nurse. I was doing regular rounds. I knew he was dead because the heart was not beating, and he didn't respond so I called the nurse. I checked (Resident #2) for a pulse and breathing. Staff E confirmed reporting Resident #2 unresponsive to Staff B. Staff E said, (Staff B) called 911, started doing CPR, and called another nurse for help. Staff E confirmed the other nurse was Staff C. Staff E confirmed the sequence of events after finding Resident #2 unresponsive was telling the nurse (Staff B), Staff B going into Resident #2's room, assessing the resident, going back to the nursing desk, calling someone, and then beginning CPR. A telephone interview on [DATE] at 9:34 a.m. with Staff C/RN regarding Resident #2 revealed she recalled working the night of [DATE] into the morning of [DATE] with some recollection of the night. Staff C confirmed a medical emergency occurred in Resident #2's room. Staff C confirmed involvement in Resident #2's code. Staff C provided a timeline of the incident events. I was in the cardiac unit. (Resident #2) belonged to another unit. Another nurse (Staff B) came to get me and I started CPR as she made the calls. I had the long hall and (Staff B) had the short hall, which included (Resident #2's) room. (Resident #2) was (Staff B's) resident for the night. (Staff B) wanted me to start the code, and she was going to make calls and get things going. I went into (Resident #2's) room to start the code and she made the overhead page for medical emergency. I cannot tell you who else was in the room, any names, or level of licensure they had, or whatever. Staff C did not know why Staff B did not immediately start CPR. She stated, .I believe (Staff B) checked the code status. To my recollection she had already checked the code status prior to me arriving on the scene. I would imagine she coordinated calls to EMS, the doctors, the family, and overhead page medical emergency. I honestly don't have a recollection who was with me performing CPR. I don't recall what time this happened. I think there was someone else who switched off with me during CPR, but I don't quite recall how many times we switched off or who it was. EMS showed up, but I have no idea what time. They hooked up the patient to their equipment and took over CPR. I have no idea about other interventions they had. When they came, I don't remember if I stayed on the scene. There is usually two or three of them and so it gets crowded but usually I stay in the periphery and so I'll run the paperwork, but I really don't remember. I usually get out of the way. I recall a wife being there, but I did not have any contact with her. The resident was deceased and did not get transferred to the hospital. Staff C continued, My role as a supervisor nurse over an LPN is to be a backup, to answer any questions, to make sure things are being done correctly. But it really is more of a resource position because I still have my own assignment. An LPN can initiate CPR. Nothing prior showed that (Staff B) was uncomfortable performing CPR. Referring to if there was an expectation for the residents' assigned nurse to perform CPR when the code status is determined, Staff C said, I mean, she could have. Most of the time I believe, it would probably be started before I came in. My first indication of a code is it is an overhead page. Sometimes someone will come running to me to tell me and then run back. Most of the time that is how it goes, normally, I would start the CPR. I don ' t know any reasons that I would not, or another nurse, would not start CPR right away. An interview on [DATE] at 10:03 a.m. with Staff B revealed she recalled Resident #2 as her usual patient on the night shift beginning at 11:00 p.m. Staff B confirmed working on Resident 2's unit and was the assigned nurse the night of the incident on [DATE]. Staff B provided a timeline of events once Resident #2 was found unresponsive on [DATE]. Staff B said, I can't totally remember the timeline, so I have to think about this. The CNA (Staff E) discovered (Resident #2), I can't remember the staff member's name. I happened to be at the nursing desk when she came and got me. I went to get my stethoscope to check the pulse, and then I went to get his chart. I saw that he was a full code. I thought I had waved at (Staff C), but I guess I went to the door and talked to her and asked her to start CPR while I started making calls to the wife, the DON, EMS. (Staff C) started CPR right away as I called 911. But I can't remember if she or I took the crash cart in there. I did not re-enter the room to assist, but I didn't do anything with the CPR. I called 911 right away. They ask questions like who is in there with the resident, their age, and that they are sending someone right away. I mean everything just flowed. I can't remember that far back. The thing was that the wife came when the EMTs were still here working on him. I was out in the hallway with her comforting her and stuff. And then EMS finished, and I said let them finish up because the resident had passed. It was a straight thing. I was not involved in performing the CPR. Referring to if CPR was immediately started for Resident #2 once the code status was determined, Staff B said, As far as I recall, the CNA (Staff E) found the resident, I notified (Staff C), and immediately started CPR. Um, I have performed CPR before. But some nurses would rather start the CPR, and some would rather initiate all the phone calling . I mean I could have (started CPR). I mean, I pulled the chart and checked that (Resident #2) was full code. I mean there's no reason I didn't start. There's no reason why. I do carry a CPR certification. On the one back in March it was valid (referring to holding a valid CPR certification during Resident #2's code), but not for (Resident #1). Not having a valid CPR card was not why I didn't start CPR on (Resident #1). I had to go back out to check (Resident #2's) chart to see if CPR was needed, and then I just went ahead and stepped inside the door to tell (Staff C) to start CPR. She could tell me no. She never said that she wanted to be the nurse starting CPR. EMS usually asks if CPR was started but I don't remember if they ask what time CPR is started. In this situation I felt that I should call 911 because I knew more about the resident, but I've started CPR before. I feel comfortable starting CPR. A telephone interview on [DATE] at 10:40 a.m. with Resident #2's wife revealed that she arrived at the facility during the incident. The wife said, I got there around the same time the medics did. They kind of shooed me out of the room. They did ask if he ever had gastro problems. I told them no, never. I know there was a lot of black that came out. I really didn't witness much. They told me that the facility had worked on him. The facility called me after he had passed. The facility let me know that my husband had passed away. I was shocked because he seemed to have been doing better. Two nurses had manually cleaned him out the night before but overall it seemed like he was improving. I had thought they had the wrong patient. He had been in the hospital because he had been sick, the hospital had released him. He was still having problems when he left the hospital. He had to be on oxygen and the facility did try and give him PT (physical therapy). When PT had come in the first time, he couldn't get up for a while. They didn't have any type of monitors on him, which I thought he needed. In my opinion, he should have never left the hospital. He did keep saying that he needs to get better and tried to push himself to do PT. His primary medical condition was that he had [MEDICAL CONDITIONS] and he had gotten one of his attacks, but he wasn't getting better. It was a combination of things. On the death record they listed that it was his heart. I took care of his advanced directive and did all that paperwork. I was involved, but the facility didn't have the staff to do what he needed. Prior to him being ill, he would walk around, do his things. He couldn't take long walks because of his breathing but that has been happening for the last [AGE] years. He was doing things around the house. At that time, he needed someone with him much more than the facility could provide. I think he left the hospital too soon. A telephone interview on [DATE] at 11:05 a.m. with the PA regarding Resident #2 revealed, We have a high turnover rate with highly skilled patients, but I do remember that it was a sudden death, unexpected. He wasn't that old either, he was pretty-young. I don't recall any details really. I can 100% tell you I wasn't in the building during the event. I really don't have anything else to offer about the incident, but if you have any additional questions feel free to call me. A review of Resident #2's County EMS Patient Care Record (run report) provided directly from the County Emergency Services, dated [DATE], revealed that the first time CPR was administered by facility was at 4:52 a.m. EMS received the call from the facility pertaining to medical emergency at 4:52 a.m. EMS was dispatched at 4:52 a.m. EMS arrived on scene at 4:57 a.m. and was at the patient at 5:00 a.m. Resuscitation was discontinued at 5:21 a.m. A review of Resident #2's clinical record revealed a progress note indicating the CNA called the nurse to the room because the resident was non-responsive at 4:40 a.m. If the resident was initially found at 4:40 a.m., as indicated in the clinical record, and CPR was first delivered by the facility staff at 4:52 a.m., as indicated on

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) the EMS run report, an elapsed timeframe of 12 minutes occurred from the time Resident #2 was found unresponsive and the initiation of CPR occurred for Resident #2. A telephone interview on [DATE] at 1:39 p.m. with the Deputy Chief of Clinical Affairs for Manatee County EMS revealed that in situations where the [MEDICAL CONDITION] was not witnessed by EMS personnel, and when CPR had already been initiated prior to their arrival, the time entered as Time 1st CPR was an approximation based on information they are provided with (from facility personnel) when they arrive on the scene. 3. A record review of Resident #1's Admission Record revealed an admission date of [DATE], and a discharge date of [DATE], with [DIAGNOSES REDACTED]. Resident #1's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008), dated [DATE], revealed the resident ambulated with an assistive device with assistance of one required for transfers. The form also noted that Resident #1 was transferred for rehabilitation and repair of sutures. A record review of Resident #1's Resident/Family Education Assessment & Interdisciplinary Flow Record, signed without a date of completion, revealed the anticipated length of stay was equal to or less than one month. The document revealed that Resident #1 had no limitations or barriers to learning, was able to understand basic information, was motivated to learn, and was able to verbalize understanding. A record review of Resident #1's Advanced Directives Discussion Document, dated [DATE], revealed a status of Provide CPR obtained by a facility nurse, signed by both Resident #1 and a Facility Representative. A review of Resident #1's Care Plan, initiated [DATE], revealed a full code status with a goal of honoring the resident's advanced directives. A record review of Resident #1's Active physician's orders [REDACTED]. A record review of Resident #1's progress notes, dated [DATE], by the Social Services Assistant (SSA), revealed that a full code status has been elected during the admission on [DATE]. The social worker spoke with the resident's daughter, per Resident #1's request, and gathered personal information. Resident #1 was living at home alone prior to arriving to the facility and received help from a private duty and the neighbor. The progress note stated that Resident #1 used a walker to ambulate. A record review of Alert Note in progress notes, dated on [DATE] at 12:45 a.m. by Licensed Practical Nurse (LPN)/Staff B, revealed, CNA came to nurse to report at 12 45am, that the resident may have passed. Pulled chart and resident was a full code. Called medical emergency to (Resident #1's room) over the intercom. Retrieved the crash cart. CPR was started by (Staff C/Staff B) and ambu bag (Bag Valve Mask used for resuscitation) was performed by (Staff A/CNA) until EMTs arrived at 1:10am. (Staff D/LPN) called 911 and printed paperwork for EMTs. EMTs called resident as deceased at 1:30am. Contacted DON (Director of Nursing) to report and to get ok to call (funeral home). Called (funeral home) around 2am. Stated they would be here in an hour and a half. Tried to contact Daughter at 1:45am, left message on voicemail to call facility, gave nurse's name and facility's phone number. An interview on [DATE] at 3:00 a.m. with Staff C revealed she was aware of Resident #1, and the incident that occurred on [DATE]. Staff C said, I was on another unit (Manatee Unit) and I was called over by (Staff B) who was caring for the resident, who was on the isolation unit (Ringling Unit). (Staff B) wanted me to pronounce the patient as deceased because I'm an RN and she is an LPN. She called me on the phone and asked me to come over and pronounce the patient being that I was the RN in the building at the time. So, I said sure and I verified that Resident #1 had expired. (Staff B) did not call me to verify a code. (Staff B) said something about how she hadn't checked (Resident #1's) code status. She asked me if I would start the code while she got the other stuff rolling and made calls. I said sure. I made sure she overhead paged medical emergency. Someone went and got the AED (Automated External Defibrillator for resuscitation), someone else got the crash cart. I started compressions before they brought the backboard. (Resident #1) was not breathing and no heartbeat. (Resident #1) was not the coldest person I ' ve ever touched. (Resident #1) was not in rigor. Staff C clarified who verified Resident #1's code status. Staff C said, both of us went out to the desk and checked it and that's when she asked me to start the code. I have no idea how much time elapsed from when (Resident #1) was found to when CPR was started. (Staff B) gave me no indication of time. I did not tell administration about the incident because (Staff B) told me she called the DON; I don't know what she told them. (Staff B) and I switched off a few times in CPR before Emergency Medical Services (EMS) got there. We performed max ,[DATE] minutes, maybe 3 switches every 50 compressions. Once EMS arrived around 1:10 a.m. I backed off and EMS performed CPR for about 20 minutes. Staff C confirmed that in Long-Term Care, the procedure once a resident is found unresponsive was to ascertain the code status if it was not already known, and if the patient was a full code then immediately start CPR. Staff C said, I don't believe (Staff B) checked the code status before she called me .but again, I was called to pronounce death. On [DATE] at 3:24 a.m., the DON and the Administrator joined the interview with Staff C. Staff C repeated the incident to administration. Staff C said, I was called over to pronounce the death of Resident #1 by (Staff B) and I came over and ascertained patient wasn't breathing, no heartbeat, and I said yep you're right she's passed. I became aware that (Staff B) wasn't sure of (Resident #1's) code status and we went to check. (Resident #1) was a full code. (Staff B) asked me if I could start CPR, and I told her she needed to call the DON. (Staff B) overhead paged medical emergency, others arrived, not sure all who, we started a code, I did compressions, the AED arrived. I can't tell you the exact number of compression rounds, but I'm thinking about 3 switches between (Staff B) and I before EMS arrived. The DON revealed that Resident #1's death was reported to her; however, no nursing staff reported a delay in checking the resident's code status or a delay in CPR initiation. The DON confirmed it was a requirement for an LPN and an RN to check a resident's code status. The DON continued saying, The expectation for incident documentation is document in the chart. I try and get a timeline of the day before (an incident) and how the resident was doing. The DON confirmed that documentation was required in a progress note which should include the last assessment, and resident status, but no other specific data points. There was a sheet on the crash cart for timeline documentation. An interview on [DATE] at 4:25 p.m. with the Physician Assistant (PA) assigned to Resident #1 revealed that the PA recalled Resident #1. The PA used Resident #1's medical chart to recall information. The PA said, She was coming to the facility for rehab. She was not being admitted for long term care at the time. She was doing physical therapy. She was a poor historian. When she came in, as far as I recall, she was making her own decisions and she did not want to sign a DNR. She wanted to be a full code. She had chest pain and was sent to the emergency room (ER) for an evaluation. The ER physician did not find anything acutely wrong with her. She came back with no change of plan that same day. Over the next few days she did not have a change of condition. I do not recall who I was called by the night of the incident, but I was called late at night. I was told patient was found non-responsive, EMS was called, she was pronounced deceased . I do not recall who called me. After the death, the MD (Medical Director) signed a death certificate stating that it was likely acute [MEDICAL CONDITION] infraction. She did have a left leg laceration . When the nurse interviewed (Resident #1), the resident was able to express that she wanted to be a Full Code. The PA reported that it was absolutely the expectation to perform the advanced directive order in place for a resident regardless of their age. An interview on [DATE] at 5:50 p.m. with Staff B revealed that she has worked in the facility for 2 years and 3 months. At the time of interview, Staff B acknowledged that her Basic Life Support (BLS) CPR card expired in [DATE]. Staff B said, I didn't know when we would be renewing it because I didn't notice renewal was posted on the back board. Staff B indicated that she recalled Resident #1, and the night of Resident #1's expiration. Staff B said, My shift started at 11:00 p.m., and I had not worked on Ringling in quite a while. The night of [DATE] was the first night I cared for the resident. Staff B provided a timeline of the incident involving Resident #1. Staff B said, Well, I can give you approximate times. About 12:45 a.m., the CNA (Staff A) came out and said she thought Resident #1 passed. I went into the room, checked the pulse, breathing, and Resident #1 had neither. I called the RN on Manatee, (Staff C/RN), and told her I had a patient that expired and asked her to come over and verify it, and she came right away. I had just pulled the chart out when (Staff C) came over. I did not go into the room with (Staff C) because I was pulling the chart to check if (Resident #1) was a full code or DNR. (Staff C) came over within a couple minutes and went into the room. I had just got the chart out. I realized she was a full code. I said Resident #1 was a full code and (Staff C/RN and Staff A/CNA) went back into the resident ' s room to begin CPR. I got the crash cart. I put the board underneath Resident #1's back and set up the ambu bag for the CNA. Before I go