STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105764	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF TALLAHASSEE	**1650 PHILLIPS RD TALLAHASSEE, FL 32308**

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 clinical and administrative record reviews, staff interview, physician interview and policy review, the facility failed to ensure a resident was free from neglect by failing to initiate Cardiopulmonary Resuscitation promptly for a resident with a full code status for 1 of 3 closed death records reviewed (resident #1). Per the facility's documentation, CPR was begun 24 to 34 minutes after the resident was found absent of pulse and respirations. This situation resulted in a finding of isolated Immediate Jeopardy at a scope and severity of J beginning on the date Resident #1 died , [DATE]. At the time of the survey 84 of the 99 residents at the facility were found to have a full code status. The Administrator was notified of the Immediate Jeopardy on [DATE] at 4:40 PM. The Immediate Jeopardy was removed on [DATE] at 3:41 PM when the facility provided evidence of immediate corrective actions. The deficient practice remains at a scope and severity level of a D. Cross reference F678 and F867. The findings include: On [DATE], the facility submitted a Nursing Homes Federal Reporting Immediate Report to the State Licensing Agency. The report was submitted subsequent to a neglect allegation that on [DATE] resident #1 expired during the evening shift (3:00 PM to 11:00 PM) as a result of the resident not receiving his morning medications that day. The facility investigated the incident, and on [DATE], submitted the results of the investigation, Nursing Homes Federal Reporting Five Day Report to the State Licensing Agency. Review of the facility's five-day report identified that the day shift nurse (7:00 AM to 3:00 PM) on [DATE] failed to identify that resident #1 was on her assignment and therefore failed to provide nursing services to resident #1 including medication administration. The report concluded that after investigation of the incident by the facility, review by the Medical Director and root cause analysis performed by the Quality Assurance and Performance Improvement (QAPI) committee, the resident's death had no correlation to the missed medications on the day shift. As part of the investigation, the facility documented a detailed timeline of events on [DATE] that transpired prior to the death of Resident #1: At 08:30 AM Resident #1 was assisted with breakfast by his assigned CNA (Certified Nursing Assistant). He ate very little. At 09:00 AM Resident #1 was assisted with a bed bath by his assigned CNA. At 09:15 AM vitals were taken by the assigned CNA. At 10:00 AM the resident was checked by the assigned CNA. At 12:00 PM the resident was checked by the assigned CNA. At 12:10 PM the Charge Nurse checked Resident #1. A friend called to ask how he was doing. Resident #1 was resting with eyes closed, no distress noted. Fluids were noted to be infusing via an intravenous line. At 12:15 PM therapy entered the room to provide therapy Services. Resident #1 was noted with increased confusion, and therapy was withheld for the day. At 12:30 PM Resident #1 was fed lunch by the assigned CNA. He consumed 25%. At 2:00 PM the resident was checked and changed by the assigned CNA. Resident #1 was quiet but responded. At 2:40 PM the assigned 3:00 PM -11:00 PM (,[DATE]) nurse came on shift. Resident #1 was checked by the oncoming Nurse. She asked him how he was doing. He moaned. At 3:20 PM Resident #1 was checked by the oncoming ,[DATE] CNA (CNA B). She noted he didn't look well. The ,[DATE] (7:00 AM to 3:00 PM) CNA (CNA A) was also in the room. The two (2) CNAs discussed Resident #1. The ,[DATE] CNA (CNA B) reported findings to the ,[DATE] Nurse (Licensed Practical Nurse C (LPN C)). At approximately 3:30 PM, the ,[DATE] nurse (LPN C) assessed Resident #1 and identified no vitals and initiated the Code Blue process, which included an overhead page. A review of the Code Blue Documentation form found in the resident's medical record identified that on [DATE] at 3:54 PM a Code Blue was called for resident #1 and also at 3:54 PM Cardiopulmonary Resuscitation (CPR) began. There was a 24 minute discrepancy between the time on the Code Blue form (3:54 PM) and the time the Code Blue process was initiated per the investigation report (approximately 3:30 PM). Staff listed as participating in the resuscitation effort beginning at 3:54 PM included LPN C and Registered Nurse D (RN D). The form was completed by the Director of Nursing (DON). Review of the Physician's Orders revealed an order dated [DATE] which stated, Code status - Full Code (meaning the individual allowed and wished to have all interventions necessary for resuscitation in the event that the individual's heart stopped working). Review of the resident's Death Record dated [DATE] identified that resident #1's cause of death was [MEDICAL CONDITION]. A review of the EMS transport records dated [DATE] in response to resident #1 showed that dispatch was notified of a [MEDICAL CONDITION] at 3:59 PM. Under the Narrative section of the report it identified that facility staff reported that they began CPR compressions at 3:54 PM. The EMS arrived at 4:04 PM and their assessment at 4:06 PM identified the resident in [MEDICAL CONDITION] with non-reactive pupils, cyanotic (blue) skin color, a cold skin temperature, and absent lung sounds. The facility provided a witness statement dated [DATE] from the ,[DATE] CNA, CNA B, who wrote, around 3:20 (PM) I was assigned to do vitals, I went into (resident #1's room) and (resident #1) did not look right to me. There was another CNA from the ,[DATE] shift (CNA A) and I asked her how long (resident #1) looked like that, and she said it was her first time working with him. I tried to do vitals and couldn't get it and called my nurse and told her he (resident #1) did not look right and something was wrong. On [DATE] at approximately 12:30 PM, CNA A (the ,[DATE] PM CNA for resident #1 on [DATE]) was interviewed. CNA A described that throughout her shift on [DATE] resident #1 was not very alert, did not eat very much for breakfast or lunch, and that on that morning the resident had requested his medications and CNA A reported that to the nurse. CNA A, expressed that she did not report any of the changes she saw in the resident because she felt that he was having a bad day and did not think he was declining in condition. CNA A reported that on [DATE] at approximately 3:20 PM the ,[DATE] CNA, CNA B, were both in the resident's room and that CNA B attempted to get the resident's vital signs but the blood pressure machine was reading error and the resident was not responsive. CNA A then stated that she walked out of the room for linens and upon her return to the room, CNA B told her she believed the resident was expiring or not breathing. CNA A reported they got the nurse on duty, LPN C, at approximately 3:30 PM to 3:35 PM. CNA A expressed that she was trained on CPR and stated that CPR should start within a matter of seconds once a person was identified without a pulse or breathing. Staff A additionally expressed she understood neglect to be failing to provide care of services to a resident and that not providing CPR in a timely manner would be considered neglectful. CNA A was not sure of the remainder of the timeline of events as other staff and nurses took over the situation. On [DATE] at approximately 12:48 PM during interview with LPN C she confirmed that she was Resident #1's nurse [DATE] on the 3:00 PM to 11:00 PM shift and that she had initiated the Code Blue process. LPN C expressed that she arrived at work at about 2:30 PM and conducted rounds on her residents where she identified that resident #1, at that time, did not look well and expressed that he was alert to person only and had a lot of confusion. From that point, she expressed she went on to her normal duties and that at some time between 3:00 PM and 3:30 PM CNA B informed her that she was unable to get vital signs and that the resident did not look well. LPN C then stated she went in to assess him and found him without a pulse and not breathing. LPN C stated that she then initiated a Code Blue over the overhead speaker and went to the nurse's station to verify the resident's code status. LPN C stated she knew he was a full code but wanted to check the chart to make sure. After she verified the resident's code status as a full code she went back to the room and initiated CPR while another staff person contacted local Emergency Medical Services (EMS) and brought the crash cart to the room. LPN C stated that she

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) did not recall the exact time CPR started but when showed the Code Blue Documentation form in the medical record she stated that the time of 3:54 PM looked correct. LPN C expressed that she was CPR certified and that she was familiar with the facility's Policy and Procedure for the initiation of CPR and stated that the residents code status should be verified and CPR should start immediately. Staff C additionally stated that she understood neglect to be not providing care to someone who is not able to perform care for themselves and expressed that not initiating CPR or failing to do so in a timely manner would be neglectful. On [DATE] at approximately 2:00 PM during interview with the facility's Medical Director, he expressed that his expectation for the facility was that they were to initiate CPR to a resident who was a full code and found unresponsive without vital signs within a couple of minutes and stated that the amount of time it takes to initiate CPR has a great impact on the effectiveness it has. He also expressed that any direct care staff should be able to recognize and identify when a resident may need CPR and that failing to initiate CPR for a resident with a full code status in a timely manner would be neglectful. The Medical Director expressed he was not aware of the amount of time it took for the facility to provide CPR to resident #1 and when shown the approximate time it took according to the facility investigation he stated that was not a quick enough response and not within the facility's expectations. On [DATE] at approximately 3:30 PM during interview with the facility Administrator, Director of Nursing, and Regional Director of Clinical Services, the Administrator defined neglect as not providing services or care, or not performing necessary duties to help a resident. The Regional Director of Clinical Services expressed that staff were expected to initiate CPR within ,[DATE] minutes at a maximum after identifying that a resident does not have vital signs and that the quicker the better. All three confirmed that CNAs receive training on CPR but are not to initiate CPR, the facility policy was for CNAs to identify the abnormal or absent vital signs and promptly notify the nurse so that the nurse could verify condition and verify code status before initiating CPR. When the surveyor asked how long it took for CPR to be initiated for resident #1 on [DATE], the regional Director of Clinical Services stated approximately 10 minutes and stated when Staff B was obtaining vital signs at approximately 3:20 PM the resident was still breathing, and CPR was not warranted. On [DATE] at approximately 4:05 PM during interview with CNA B, she expressed that on [DATE] at approximately 3:15 PM- 3:20 PM she went into resident #1's room to obtain vital signs. She expressed that at the time that she walked into the room the resident was breathing very shallowly and, shortly after, she could not see him breathing anymore and stated, I felt like I saw him take his last breath and was unable to obtain other vital signs. She stated that she talked with CNA A about the resident's condition and she felt like something was wrong and then they alerted LPN C. CNA B expressed she was unsure of what time CPR started because she left the area to perform other duties. On [DATE] at approximately 4:30 PM during follow-up interview with LPN C to confirm the timeline, LPN C reiterated that between 3:15 PM and 3:20 PM on [DATE] she was alerted that the CNAs for resident #1 were unable to obtain vital signs and she went in to assess him and he was not breathing, had no pulse and that CPR was started after that with another nurse, Registered Nurse D (RN D). At the time of interview, a nursing note was reviewed with LPN C and she confirmed it was the only note she had written that day concerning the resident and CPR. The note was dated [DATE] at 10:28 PM and described that the assigned CNA for resident #1 was unable to obtain vital signs so she assessed the resident after which a Code Blue was initiated, CPR began, and 911 was called. The nurse's note did not have times for when the CNA alerted the nurse or when the nurse assessed the resident or began CPR. LPN C confirmed the only place that described when CPR began was on the Code Blue Documentation form. On [DATE] at approximately 12:36 PM during interview with RN D, he expressed that on [DATE] he heard Code Blue over the loudspeaker while in his work office and rushed to resident #1's room. RN D was unsure of the time he heard the Code Blue call but stated that once in the room another staff went to verify the resident's code status and call 911. When they returned, it was announced the resident was a full code and CPR began. Staff D stated that CPR began before 4:00 PM and when showed the Code Blue Documentation stated that the time of 3:54 PM that was documented was the correct time that CPR began. On [DATE] at 1:41 PM, the DON requested an interview with the surveyor stating that she wrote the times wrong on the Code Blue form. A telephone call interrupted the interview. At 2:19 PM, the DON returned to discuss the recorded times. At that time, the DON was informed that the EMS report matches exactly with the times written on Code Blue form, and the DON stated, never mind and concluded the interview. A review of the facility policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation with a revision date of [DATE], defined neglect as the failure of the center, its employees or service providers to provide goods and services that are necessary to avoid physical harm, pain, mental anguish or emotional distress. According to the American Heart Association, FACTS, A Race Against the Clock, Out-of-Hospital [MEDICAL CONDITION], dated [DATE], which is currently posted to their website, [MEDICAL CONDITION] occurs when the heart's electrical system abruptly malfunctions and the heart suddenly stops beating normally .to survive [MEDICAL CONDITION], they must receive immediate cardiopulmonary resuscitation (CPR) to increase blood flow to the heart and brain . for every minute without lifesaving CPR and defibrillation, chances of survival decrease 7%-10%. . The Immediate Jeopardy was removed onsite on [DATE] after receipt of an acceptable removal plan and verification of corrective actions. On [DATE] at approximately 3:41 PM the removal plan was verified after staff interviews to determine knowledge on neglect, CPR, the facility policy on CPR, and participation in mock drills. A record review was conducted of training in-service records for 48 of 99 nursing staff on neglect, mock drills for CPR. -The Director of Nursing/Designee re-educated current facility licensed nursing and certified nursing staff in the facility on [DATE] and will continue education through [DATE] at the beginning of each shift before staff work their assignments, regarding the facility's policy and procedures regarding medical neglect which is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. On [DATE] between 2:35 PM, and 3:30 PM, the surveyor conducted interviews with CNA E, CNA G, LPN F and LPN H. All staff were able to define neglect and reported that they had recently been retrained on neglect. A record review of training documentation showed education on resident rights. Education was ongoing for all topics and being implemented as staff arrived at work. Training had been implemented for approximately 48 of 99 CNA and nurse staff at the time of review. -The Director of Nursing/Designee re-educated current facility licensed nursing and certified nursing staff in the facility on [DATE] and will continue education through [DATE] at the beginning of each shift before staff work their assignments, regarding the facility's policy and procedures regarding: 1. Honoring resident's Advanced Directives 2. DNR orders 3. Change of condition, 4. Code Blue Process 5. CPR 6. Resident Rights 7. Accurate and complete documentation in the medical record The surveyor verified training documentation. On [DATE] between 2:35 PM, and 3:30 PM, the surveyor conducted interviews with CNA E, CNA G, LPN F and LPN H. The staff all reported recent retraining, and were able to express what a resident's code status meant, where to locate it in the medical record, and the facility's procedure for initiating CPR. A record review of training documentation showed education on CPR, advanced directives, code blue process, signs and symptoms of respiratory distress and what should be reported to the nurse immediately by CNA's, vital signs and when to report them, code blue documentation accuracy, CPR policy and procedure, and resident rights. Education was ongoing for all topics and being implemented as staff arrived at work. Training had been implemented for approximately 48 of 99 CNA and nurse staff at the time of review. -On ,[DATE] - ,[DATE] Mock Code Drills were completed each shift by the Director of Nursing/Designee to ensure compliance of facility policy and procedures regarding advanced directives. Mock drills have been completed on [DATE] at 2:37 PM with training of 15 CNAs and 9 licensed nurses, [DATE] at 7:04 PM with training of 10 CNAs and 5 licensed nurses and [DATE] at 10:52 PM with training of 7 CNAs and 4 licensed nurses. Mock code drills will continue daily. The surveyor verified training documentation. On [DATE] between 2:35 PM, and 3:30 PM, the surveyor conducted interviews with CNA E, CNA G, LPN F and LPN H. The staff all reported participation in mock Code Blue drills in the past 24 hours. -On [DATE], the Social Services Director completed an additional audit of the current facility residents to verify the residents advanced directives/code status, physician's orders and DNR or code documentation correctly reflected the resident's wishes in the medical records per the facility policy and procedures. The surveyor reviewed documentation of code status audits with no concerns.
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 clinical and administrative record reviews, staff interview, physician interview, policy review and review of the American Heart Association Cardiopulmonary Resuscitation (CPR) guidance, the facility failed to initiate CPR promptly for a resident whose advance directives desired CPR (full code status) in the event of [MEDICAL CONDITION] for 1 of 3 closed death records reviewed (resident #1). Per the facility's documentation, CPR was begun 24 to 34 minutes after the resident

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) was found absent of pulse and respirations. This situation resulted in a finding of isolated Immediate Jeopardy at a scope and severity of J beginning on the date Resident #1 died , [DATE]. At the time of the survey 84 of the 99 residents at the facility were found to have a full code status. The Administrator was notified of the Immediate Jeopardy on [DATE] at 4:40 PM. The Immediate Jeopardy was removed on [DATE] at 3:41 PM when the facility provided evidence of immediate corrective actions. The deficient practice remains at a scope and severity level of a D. Cross reference F600 and F867. The findings include: Review of Resident #1's Florida Death Record dated [DATE] identified that resident #1's cause of death was [MEDICAL CONDITION] with the identified significant conditions of [MEDICAL CONDITION] (disease, damage, or blockage of the hearts major blood vessels), Diabetes Mellitus type 2 (a chronic condition that affects how blood sugar is processed), Chronic Obstructive [MEDICAL CONDITION] Disorder (lung disease that restrict airflow and causes difficulty breathing), [MEDICAL CONDITION] Fibrillation (an irregular heart rate that can cause poor blood flow), and a history of triple Coronary Artery Bypass Graft (a surgical procedure used to restore blood flow to the heart by bypassing three affected arteries). Review of the Physician's Orders revealed an order dated [DATE] which stated, Code status - Full Code (meaning the individual allowed and wished to have all interventions necessary for resuscitation in the event that the individual's heart stopped working). On [DATE], the facility submitted a Nursing Homes Federal Reporting Immediate Report to the State Licensing Agency. The report was submitted subsequent to a neglect allegation that on [DATE] resident #1 expired during the evening shift (3:00 PM to 11:00 PM) as a result of the resident not receiving his morning medications that day. The facility investigated the incident, and on [DATE], submitted the results of the investigation, Nursing Homes Federal Reporting Five Day Report to the State Licensing Agency. Review of the facility's five-day report identified that the day shift nurse (7:00 AM to 3:00 PM) on [DATE] failed to identify that resident #1 was on her assignment and therefore failed to provide nursing services to resident #1 including medication administration. The report concluded that after investigation of the incident by the facility, review by the Medical Director and root cause analysis performed by the Quality Assurance and Performance Improvement (QAPI) committee, the resident's death had no correlation to the missed medications on the day shift. As part of the investigation, the facility documented a detailed timeline of events on [DATE] that transpired prior to the death of Resident #1: At 08:30 AM Resident #1 was assisted with breakfast by his assigned CNA (Certified Nursing Assistant). He ate very little. At 09:00 AM Resident #1 was assisted with a bed bath by his assigned CNA. At 09:15 AM vitals were taken by the assigned CNA. At 10:00 AM the resident was checked by the assigned CNA. At 12:00 PM the resident was checked by the assigned CNA. At 12:10 PM the Charge Nurse checked Resident #1. A friend called to ask how he was doing. Resident #1 was resting with eyes closed, no distress noted. Fluids were noted to be infusing via an intravenous line. At 12:15 PM therapy entered the room to provide therapy Services. Resident #1 was noted with increased confusion, and therapy was withheld for the day. At 12:30 PM Resident #1 was fed lunch by the assigned CNA. He consumed 25%. At 2:00 PM the resident was checked and changed by the assigned CNA. Resident #1 was quiet but responded. At 2:40 PM the assigned 3:00 PM -11:00 PM (,[DATE]) nurse came on shift. Resident #1 was checked by the oncoming Nurse. She asked him how he was doing. He moaned. At 3:20 PM Resident #1 was checked by the oncoming ,[DATE] CNA (CNA B). She noted he didn't look well. The ,[DATE] (7:00 AM to 3:00 PM) CNA (CNA A) was also in the room. The two (2) CNAs discussed Resident #1. The ,[DATE] CNA (CNA B) reported findings to the ,[DATE] Nurse (Licensed Practical Nurse C (LPN C)). At approximately 3:30 PM, the ,[DATE] nurse (LPN C) assessed Resident #1 and identified no vitals and initiated the Code Blue process, which included an overhead page. A review of the Code Blue Documentation form found in the resident's medical record identified that on [DATE] at 3:54 PM a Code Blue was called for resident #1 and also at 3:54 PM CPR began. There was a 24 minute discrepancy between the time on the Code Blue form (3:54 PM) and the time the Code Blue process was initiated per the investigation report (approximately 3:30 PM). Staff listed as participating in the resuscitation effort beginning at 3:54 PM included LPN C and Registered Nurse D (RN D). The form was completed by the Director of Nursing (DON). A review of the EMS transport records dated [DATE] in response to resident #1 showed that dispatch was notified of a [MEDICAL CONDITION] at 3:59 PM. Under the Narrative section of the report it identified that facility staff reported that they began CPR compressions at 3:54 PM. The EMS arrived at 4:04 PM and their assessment at 4:06 PM identified the resident in [MEDICAL CONDITION] with non-reactive pupils, cyanotic (blue) skin color, a cold skin temperature, and absent lung sounds. Additional record reviews and interviews were conducted regarding the timeline discrepancy. The facility provided a witness statement dated [DATE] from the ,[DATE] CNA, CNA B, who wrote, around 3:20 (PM) I was assigned to do vitals, I went into (resident #1's room) and (resident #1) did not look right to me. There was another CNA from the ,[DATE] shift (CNA A) and I asked her how long (resident #1) looked like that, and she said it was her first time working with him. I tried to do vitals and couldn't get it and called my nurse and told her he (resident #1) did not look right and something was wrong. On [DATE] at approximately 12:30 PM, CNA A (the ,[DATE] PM CNA for resident #1 on [DATE]) was interviewed. CNA A described that throughout her shift on [DATE] resident #1 was not very alert, did not eat very much for breakfast or lunch, and that on that morning the resident had requested his medications and CNA A reported that to the nurse. CNA A, expressed that she did not report any of the changes she saw in the resident because she felt that he was having a bad day and did not think he was declining in condition. CNA A reported that on [DATE] at approximately 3:20 PM the ,[DATE] CNA, CNA B, were both in the resident's room and that CNA B attempted to get the resident's vital signs but the blood pressure machine was reading error and the resident was not responsive. CNA A then stated that she walked out of the room for linens and upon her return to the room, CNA B told her she believed the resident was expiring or not breathing. CNA A reported they got the nurse on duty, LPN C, at approximately 3:30 PM to 3:35 PM. CNA A expressed that she was trained on CPR and stated that CPR should start within a matter of seconds once a person was identified without a pulse or breathing. CNA A was not sure of the remainder of the timeline of events as other staff and nurses took over the situation. On [DATE] at approximately 12:48 PM during interview with LPN C she confirmed that she was Resident #1's nurse [DATE] on the 3:00 PM to 11:00 PM shift and that she had initiated the Code Blue process. LPN C expressed that she arrived at work at about 2:30 PM and conducted rounds on her residents where she identified that resident #1, at that time, did not look well and expressed that he was alert to person only and had a lot of confusion. From that point, she expressed she went on to her normal duties and that at some time between 3:00 PM and 3:30 PM CNA B informed her that she was unable to get vital signs and that the resident did not look well. LPN C then stated she went in to assess him and found him without a pulse and not breathing. LPN C stated that she then initiated a Code Blue over the overhead speaker and went to the nurse's station to verify the resident's code status. LPN C stated she knew he was a full code but wanted to check the chart to make sure. After she verified the resident's code status as a full code she went back to the room and initiated CPR while another staff person contacted local Emergency Medical Services (EMS) and brought the crash cart to the room. LPN C stated that she did not recall the exact time CPR started but when showed the Code Blue Documentation form in the medical record she stated that the time of 3:54 PM looked correct. LPN C expressed that she was CPR certified and that she was familiar with the facility's Policy and Procedure for the initiation of CPR and stated that the residents code status should be verified and CPR should start immediately. On [DATE] at approximately 3:30 PM during interview with the facility Administrator, Director of Nursing, and Regional Director of Clinical Services the Regional Director of Clinical Services expressed that staff were expected to initiate CPR within ,[DATE] minutes at a maximum after identifying that a resident does not have vital signs and that the quicker the better. All three confirmed that CNAs receive training on CPR but are not to initiate CPR, the facility policy was for CNAs to identify the abnormal or absent vital signs and promptly notify the nurse so that the nurse could verify condition and verify code status before initiating CPR. When the surveyor asked how long it took for CPR to be initiated for resident #1 on [DATE] the regional Director of Clinical Services stated approximately 10 minutes and stated when Staff B was obtaining vital signs at approximately 3:20 PM the resident was still breathing, and CPR was not warranted. On [DATE] at approximately 4:05 PM during interview with CNA B, she expressed that on [DATE] at approximately 3:15 PM- 3:20 PM she went into resident #1's room to obtain vital signs. She expressed that at the time that she walked into the room the resident was breathing very shallowly and, shortly after, she could not see him breathing anymore and stated, I felt like I saw him take his last breath and was unable to obtain other vital signs. She stated that she talked with CNA A about the resident's condition and she felt like something was wrong and then they alerted LPN C. CNA B expressed she was unsure of what time CPR started because she left the area to perform other duties. On [DATE] at approximately 4:30 PM during follow-up interview with LPN C to confirm the timeline, LPN C reiterated that between 3:15 PM and 3:20 PM on [DATE] she was alerted that the CNAs for resident #1 were unable to obtain vital signs and she went in to assess him and he was not breathing, had no pulse and that CPR was started after that with another nurse, Registered Nurse D (RN D). At the time of interview, a nursing note was reviewed with LPN C and she confirmed it was the only note she had written that day concerning the resident and CPR. The note was dated [DATE] at 10:28 PM and described that the assigned CNA for resident #1 was unable to

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F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) obtain vital signs so she assessed the resident after which a Code Blue was initiated, CPR began, and 911 was called. The nurse's note did not have times for when the CNA alerted the nurse or when the nurse assessed the resident or began CPR. LPN C confirmed the only place that described when CPR began was on the Code Blue Documentation form. On [DATE] at approximately 12:36 PM during interview with RN D, he expressed that on [DATE] he heard Code Blue over the loudspeaker while in his work office and rushed to resident #1's room. RN D was unsure of the time he heard the Code Blue call but stated that once in the room another staff went to verify the resident's code status and call 911. When they returned, it was announced the resident was a full code and CPR began. Staff D stated that CPR began before 4:00 PM and when showed the Code Blue Documentation stated that the time of 3:54 PM that was documented was the correct time that CPR began. On [DATE] at 1:41 PM, the DON requested an interview with the surveyor stating that she wrote the times wrong on the Code Blue form. A telephone call interrupted the interview. At 2:19 PM, the DON returned to discuss the recorded times. At that time, the DON was informed that the EMS report matches exactly with the times written on Code Blue form, and the DON stated, never mind and concluded the interview. On [DATE] at approximately 2:00 PM during interview with the facility's Medical Director, he expressed that his expectation for the facility was that they were to initiate CPR to a resident who was a full code and found unresponsive without vital signs within a couple of minutes and stated that the amount of time it takes to initiate CPR has a great impact on the effectiveness it has. He also expressed that any direct care staff should be able to recognize and identify when a resident may need CPR. The Medical Director expressed he was not aware of the amount of time it took for the facility to provide CPR to resident #1 and when shown the approximate time it took according to the facility investigation he stated that was not a quick enough response and not within the facility's expectations. A review of the facility policy and procedure, Florida Cardiopulmonary Resuscitation (CPR) dated [DATE], stated that Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in [MEDICAL CONDITION] unless such a resident has a fully executed Florida Do Not Resuscitate (DNR) order. The policy and procedure described that in the event of [MEDICAL CONDITION], staff were to immediately call for assistance and two licensed nurses were to verify the resident and whether or not the resident had a DNR order, after which Code Blue was to be called over the paging system and in the absences of a DNR order CPR was to immediately begin. A review of the American Heart Association, FACTS, A Race Against the Clock, Out-of-Hospital [MEDICAL CONDITION], dated [DATE], which is currently posted to their website, [MEDICAL CONDITION] occurs when the heart's electrical system abruptly malfunctions and the heart suddenly stops beating normally .to survive [MEDICAL CONDITION], they must receive immediate cardiopulmonary resuscitation (CPR) to increase blood flow to the heart and brain . for every minute without lifesaving CPR and defibrillation, chances of survival decrease 7%-10%. The Immediate Jeopardy was removed onsite on [DATE] after receipt of an acceptable removal plan and verification of corrective actions. On [DATE] at approximately 3:41 PM the removal plan was verified after staff interviews to determine knowledge on CPR, the facility policy on CPR, and participation in mock drills. A record review of training confirmed in-service records for 48 of 99 Nursing staff, and mock CPR drills. -The Director of Nursing/Designee re-educated current facility licensed nursing and certified nursing staff in the facility on [DATE] and will continue education through [DATE] at the beginning of each shift before staff work their assignments, regarding the facility's policy and procedures regarding: 1. Honoring resident's Advanced Directives 2. DNR orders 3. Change of condition, 4. Code Blue Process 5. CPR 6. Resident Rights 7. Accurate and complete documentation in the medical record The surveyor verified training documentation. On [DATE] between 2:35 PM, and 3:30 PM, the surveyor conducted interviews with CNA E, CNA G, LPN F and LPN H. The staff all reported recent retraining, and were able to express what a resident's code status meant, where to locate it in the medical record, and the facility's procedure for initiating CPR. A record review of training documentation showed education on CPR, advanced directives, code blue process, signs and symptoms of respiratory distress and what should be reported to the nurse immediately by CNA's, vital signs and when to report them, code blue documentation accuracy, CPR policy and procedure, and resident rights. Education was ongoing for all topics and being implemented as staff arrived at work. Training had been implemented for approximately 48 of 99 CNA and nurse staff at the time of review. -On ,[DATE] - ,[DATE] Mock Code Drills were completed each shift by the Director of Nursing/Designee to ensure compliance of facility policy and procedures regarding advanced directives. Mock drills have been completed on [DATE] at 2:37 PM with training of 15 CNAs and 9 licensed nurses, [DATE] at 7:04 PM with training of 10 CNAs and 5 licensed nurses and [DATE] at 10:52 PM with training of 7 CNAs and 4 licensed nurses. Mock code drills will continue daily. The surveyor verified training documentation. On [DATE] between 2:35 PM, and 3:30 PM, the surveyor conducted interviews with CNA E, CNA G, LPN F and LPN H. The staff all reported participation in mock Code Blue drills in the past 24 hours. -On [DATE], the Social Services Director completed an additional audit of the current facility residents to verify the residents advanced directives/code status, physician's orders and DNR or code documentation correctly reflected the resident's wishes in the medical records per the facility policy and procedures. The surveyor reviewed documentation of code status audits with no concerns.
F 0867 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical and administrative record reviews, staff interview, physician interview, policy review, and review of the American Heart Association Cardiopulmonary Resuscitation (CPR) guidance, the facility Quality Assurance and Performance Improvement (QAPI) committee failed to identify a CPR time delay and develop corrective actions during review of a neglect allegation for 1 of 3 sampled closed death records (resident #1). Per the facility's documentation, CPR was begun 24 to 34 minutes after the resident was found absent of pulse and respirations. This situation resulted in a finding of isolated Immediate Jeopardy at a scope and severity of J beginning on the date Resident #1 died , [DATE]. At the time of the survey 84 of the 99 residents at the facility were found to have a full code status. The Administrator was notified of the Immediate Jeopardy on [DATE] at 4:40 PM. The Immediate Jeopardy was removed on [DATE] at 3:41 PM when the facility provided evidence of immediate corrective actions. The deficient practice remains at a scope and severity level of a D. Cross reference F600 and F678. The findings include: On [DATE], the facility submitted a Nursing Homes Federal Reporting Immediate Report to the State Licensing Agency. The report was submitted subsequent to a neglect allegation that on [DATE] resident #1 expired during the evening shift (3:00 PM to 11:00 PM) as a result of the resident not receiving his morning medications that day. The facility investigated the incident, and on [DATE], submitted the results of the investigation to the State Licensing Agency. Review of the facility's five-day report identified that the day shift nurse (7:00 AM to 3:00 PM) on [DATE] failed to identify that resident #1 was on her assignment and therefore failed to provide nursing services to resident #1 including medication administration. The report concluded that after investigation of the incident by the facility, review by the Medical Director and root cause analysis performed by the QAPI committee, the resident's death had no correlation to the missed medications on the day shift. The report did not identify any concerns with the timeline of the initiation of CPR. As part of the investigation, the report documented a detailed timeline of events on [DATE] that transpired prior to the death of Resident #1 which included: At 2:40 PM the assigned 3:00 PM -11:00 PM (,[DATE]) nurse came on shift. Resident #1 was checked by the oncoming Nurse. She asked him how he was doing. He moaned. At 3:20 PM Resident #1 was checked by the oncoming ,[DATE] CNA (CNA B). She noted he didn't look well. The ,[DATE] (7:00 AM to 3:00 PM) CNA (CNA A) was also in the room. The two (2) CNAs discussed Resident #1. The ,[DATE] CNA (CNA B) reported findings to the ,[DATE] Nurse (Licensed Practical Nurse C (LPN C)). At approximately 3:30 PM, the ,[DATE] nurse (LPN C) assessed Resident #1 and identified no vitals and initiated the Code Blue process, which included an overhead page. A review of the Code Blue Documentation form found in the resident's medical record identified that on [DATE] at 3:54 PM a Code Blue was called for resident #1 and also at 3:54 PM CPR began. There was a 24 minute discrepancy between the time on the Code Blue form (3:54 PM) and the time the Code Blue process was initiated per the investigation report (approximately 3:30 PM). A review of the EMS transport records dated [DATE] in response to resident #1 showed that dispatch was notified of a [MEDICAL CONDITION] at 3:59 PM. Under the Narrative section of the report it identified that facility staff reported that they began CPR compressions at 3:54 PM. The EMS arrived at 4:04 PM and their assessment at 4:06 PM identified the resident in [MEDICAL CONDITION] with non-reactive pupils, cyanotic (blue) skin color, a cold skin temperature, and absent lung sounds. A clinical record review found one nursing note documented by LPN C concerning the resident and CPR. The note was dated [DATE] at 10:28 PM and described that the assigned CNA for resident #1 was unable to obtain vital signs so she assessed the resident after which a Code Blue was initiated, CPR began, and 911 was called. The nurse's note did not have times for when the CNA alerted the nurse or when the nurse assessed the resident or began CPR. A review of the facility investigation was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105764	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF TALLAHASSEE	**1650 PHILLIPS RD TALLAHASSEE, FL 32308**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0867 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) conducted. The investigation included several witness statements, but the witness statements were mainly focused on the resident assignments and missed morning medications, not the delay in CPR. In interview on [DATE] at approximately 12:30 PM, CNA A (the ,[DATE] AM CNA for resident #1 on [DATE]) reported that on [DATE] at approximately 3:20 PM both she and the ,[DATE] CNA, CNA B, were resident#1's room and that CNA B attempted to get the resident's vital signs but the blood pressure machine was reading error and the resident was not responsive. CNA A then stated that she walked out of the room for linens and upon her return to the room, CNA B told her she believed the resident was expiring or not breathing. CNA A reported they got the nurse on duty, LPN C, at approximately 3:30 PM to 3:35 PM. On [DATE] at approximately 12:48 PM during interview with LPN C she confirmed that she was Resident #1's nurse [DATE] on the 3:00 PM to 11:00 PM shift and that she had initiated the Code Blue process. LPN C expressed that at some time between 3:00 PM and 3:30 PM CNA B informed her that she was unable to get vital signs and that the resident did not look well. LPN C then stated she went in to assess him and found him without a pulse and not breathing. LPN C stated that she then initiated a Code Blue over the overhead speaker and went to the nurse's station to verify the resident's code status. LPN C stated she knew he was a full code but wanted to check the chart to make sure. After she verified the resident's code status as a full code she went back to the room and initiated CPR while another staff person contacted local Emergency Medical Services (EMS) and brought the crash cart to the room. LPN C stated that she did not recall the exact time CPR started but when showed the Code Blue Documentation form in the medical record she stated that the time of 3:54 PM looked correct. On [DATE] at approximately 2:00 PM during interview with the facility's Medical Director, he expressed he was not aware of the amount of time it took for the facility to provide CPR to resident #1 and when shown the approximate time it took according to the facility investigation he stated that was not a quick enough response and not within the facility's expectations. On [DATE] at approximately 3:30 PM during interview with the facility Administrator, Director of Nursing, and Regional Director of Clinical Services, the Administrator defined neglect as not providing services or care, or not performing necessary duties to help a resident. The Administrator discussed that when reviewing resident #1's death that the QAPI committee identified issues related to the resident being missed by the nurse's assignment and the fact that the resident missed his medications. The administrator denied the inclusion of CPR response time in their Ad Hoc QAPI meeting held on [DATE] and stated they had not identified any issues with the staff's response time in CPR during the incident. The Regional Director of Clinical Services expressed that staff were expected to initiate CPR within ,[DATE] minutes at a maximum after identifying that a resident does not have vital signs and that the quicker the better. All three confirmed that CNAs receive training on CPR but are not to initiate CPR, the facility policy was for CNAs to identify the abnormal or absent vital signs and promptly notify the nurse so that the nurse could verify condition and verify code status before initiating CPR. When questioned how long it took for CPR to be initiated for resident #1 on [DATE] the regional Director of Clinical Services stated approximately 10 minutes and stated when Staff B was obtaining vital signs at approximately 3:20 PM the resident was still breathing, and CPR was not warranted. The regional Director of Clinical Services further stated that the QAPI committee had identified concerns that the nurse on duty from 7:00 AM to 3:00 PM on [DATE] had failed to identify that resident #1 was on her assignment and the focus of the Ad Hoc QAPI meeting was to address that issue. A record review of the Ad Hoc Quality Assurance and Performance Improvement Meeting notes provided by the facility Administrator found that the meeting notes did not address any concerns related to the time it took staff to identify the need for and initiate CPR for resident #1. The Immediate Jeopardy was removed onsite on [DATE] after receipt of an acceptable removal plan and verification of corrective actions. On [DATE] at approximately 3:41 PM the removal plan was verified after staff interviews to determine knowledge on CPR, the facility policy on CPR, and participation in mock drills. A record review of training confirmed in-service records for 48 of 99 Nursing staff, and mock CPR drills. A QAPI interview and record review confirmed inclusion of CPR initiation and neglect into the facility's QAPI plan. -Ad Hoc QAPI meeting was conducted on [DATE] with the IDT team which included the Medical Director via telephone, Administrator, Director of Nurses, Regional Director of Nurses, Social Services Director, MDS coordinator and Medical Records Director reviewing the regulations for F600, F678 and F867. The corrective plan for the citations were also reviewed along with a review the current CPR policy and policy for Abuse, Neglect, Exploitation and Misappropriation. Ad Hoc QAPI meeting notes were provided to the surveyor and revealed the inclusion of the necessary members of the QAPI committee. The minutes showed a QAPI review of CPR documentation and identification of change of condition as areas of concern with education and mock drills in place to correct. Interview with the administrator and DON at 3:30 PM on [DATE], the Administrator stated We had our QAPI meeting with the Medical Director on the phone and we talked through what we needed to do and education and how to implement that education. We also talked about how to maintain that education and to include it in monthly education. We also talked about and included audits of all residents advanced directives and their flow sheets that are maintained in the front of the medical record. We did a total of three mock drills, so far and those went well. -The Director of Nursing/Designee re-educated current facility licensed nursing and certified nursing staff in the facility on [DATE] and will continue education through [DATE] at the beginning of each shift before staff work their assignments, regarding the facility's policy and procedures regarding: 1. Honoring resident's Advanced Directives 2. DNR orders 3. Change of condition, 4. Code Blue Process 5. CPR 6. Resident Rights 7. Accurate and complete documentation in the medical record The surveyor verified training documentation. On [DATE] between 2:35 PM, and 3:30 PM, the surveyor conducted interviews with CNA E, CNA G, LPN F and LPN H. The staff all reported recent retraining, and were able to express what a resident's code status meant, where to locate it in the medical record, and the facility's procedure for initiating CPR. A record review of training documentation showed education on CPR, advanced directives, code blue process, signs and symptoms of respiratory distress and what should be reported to the nurse immediately by CNA's, vital signs and when to report them, code blue documentation accuracy, CPR policy and procedure, and resident rights. Education was ongoing for all topics and being implemented as staff arrived at work. Training had been implemented for approximately 48 of 99 CNA and nurse staff at the time of review. -On ,[DATE] - ,[DATE] Mock Code Drills were completed each shift by the Director of Nursing/Designee to ensure compliance of facility policy and procedures regarding advanced directives. Mock drills have been completed on [DATE] at 2:37 PM with training of 15 CNAs and 9 licensed nurses, [DATE] at 7:04 PM with training of 10 CNAs and 5 licensed nurses and [DATE] at 10:52 PM with training of 7 CNAs and 4 licensed nurses. Mock code drills will continue daily. The surveyor verified training documentation. On [DATE] between 2:35 PM, and 3:30 PM, the surveyor conducted interviews with CNA E, CNA G, LPN F and LPN H. The staff all reported participation in mock Code Blue drills in the past 24 hours. -On [DATE], the Social Services Director completed an additional audit of the current facility residents to verify the residents advanced directives/code status, physician's orders [REDACTED]. The surveyor reviewed documentation of code status audits with no concerns. -The Director of Nursing/Designee re-educated current facility licensed nursing and certified nursing staff in the facility on [DATE] and will continue education through [DATE] at the beginning of each shift before staff work their assignments, regarding the facility's policy and procedures regarding medical neglect which is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. On [DATE] between 2:35 PM, and 3:30 PM, the surveyor conducted interviews with CNA E, CNA G, LPN F and LPN H. All staff were able to define neglect and reported that they had recently been retrained on neglect. A record review of training documentation showed education on resident rights. Education was ongoing for all topics and being implemented as staff arrived at work. Training had been implemented for approximately 48 of 99 CNA and nurse staff at the time of review.