STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105533	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENTS PARK OF JACKSONVILLE	**8700 A C SKINNER PARKWAY JACKSONVILLE, FL 32256**

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 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to meet professional standards of quality for one (Resident #1) of three sampled residents who experienced an acute change in condition, by failing to appropriately assess the resident's condition and transfer them to a higher level of care as ordered by the physician for one (Resident #1) of three sampled residents who experienced an acute change in condition. The facility staff delayed Resident #1's hospital transfer for six hours, until she went into [MEDICAL CONDITION]. After attempted resuscitation and hospital transfer, she later died . This also placed the facility's 103 other current residents at risk of not receiving appropriate care following an acute change in condition. Professional standards of quality means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. The Florida Nurse Practice Act, Chapter 464.003 defines the practice of professional nursing as, The performance of those acts requiring substantial specialized knowledge, judgment and nursing skill based upon applied principles of psychological, biological, physical and social sciences, which shall include but is not limited to: the administration of medications and treatments as prescribed or authorized by a duly licensed practitioner. The practice of practical nursing is the performance of selected acts, including the administration of treatments and medications in the care of the ill, injured or infirmed and the promotion of wellness, maintenance or health, and the prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician or a licensed dentist. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 3:00 p.m. on [DATE]. On [DATE] at 3:30 p.m., the Immediate Jeopardy (IJ) began. Throughout the survey, the facility provided their immediate actions to remove IJ, and these immediate actions were verified as having been completed by the survey team. On [DATE] at 6:50 p.m., the Administrator was notified of the IJ determination, and immediate jeopardy was removed at the time of survey exit on [DATE] at 7:00 PM. The facility remained out of compliance, and the scope and severity were reduced to a D. The findings include: Cross reference to F684. A review of Resident #1's clinical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The resident had documented wishes to be resuscitated in the event of a [MEDICAL CONDITION] (full code). A review of the resident's most recent Minimum Data Set (MDS) assessment (quarterly), with an assessment reference date of [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 possible points, indicating severe cognitive impairment. The resident required extensive assistance of one staff member with most activities of daily living (ADLs), except for meals, for which she only required supervision. Further review of the clinical record revealed that from the date of admission on [DATE] through [DATE], the resident had not experienced any [MEDICAL CONDITION]-type activity. A review of Resident #1's respiratory record history from [DATE] through [DATE], revealed her average respiratory rate (RR) was ,[DATE] breaths per minute. A review of the [DATE] physician's orders [REDACTED]. A review of the resident's lab work showed that on [DATE], blood was drawn for a therapeutic level of [MEDICATION NAME], revealing suboptimal concentrations of the medication and a [MEDICATION NAME] level of 6.7 ug/ml (micrograms per milliliter). The normal range was noted as ,[DATE] ug/ml. This left Resident #1 more susceptible to [MEDICAL CONDITION] activity, and the resident's physician increased her [MEDICATION NAME] dosage from 100 mg twice daily to 300 mg at bedtime on [DATE]. In LPN A's nursing progress note dated [DATE] at 4:44 PM, she documented that she went to assess the resident with the two other nurses (RN B and RN C), and the resident's oxygen saturation dropped to 89% on room air with a RR of 26. The resident was rechecked and had a temperature of 99.2 degrees Fahrenheit (F) and RR 26 with slight twitching from head to toe. She noted that Resident #1 was placed on oxygen via face mask at 10 liters per minute and the oxygen saturation came up to 99%. A review of Resident #1's current physician's orders [REDACTED]. In LPN A's nursing progress note dated [DATE] at 4:54 PM, she documented that a telephone order was received from the physician instructing staff to, Send resident to ER for [MEDICAL CONDITION]/uncontrolled [MEDICATION NAME] levels. Based on a review of the resident's clinical record and a review of the facility's investigation documentation, on [DATE], Employee A, Licensed Practical Nurse (LPN), was working the day shift (7AM - 3PM) providing care on the unit where Resident #1 lived. Employee B, Registered Nurse (RN), was also working on that shift, and at 3:00 PM, Employee C, RN, came on duty to work the evening shift (3PM - 11PM) and to care for Resident #1. In a written statement, dated [DATE] at 3:30 PM, RN C wrote that during change of shift rounds, he found Resident #1 with a respiratory rate (RR) of 26, twitching activity, and she was not responding to painful stimulation. He documented that oxygen was started at 2 liters per minute. He called LPN A and RN B to assess the resident and documented that an order was received from the physician to send the resident to the emergency room (ER) for evaluation. In a written statement, dated [DATE], RN B recorded that she had been called to Resident #1's room to take a look at the resident, but at no time did she put a stethoscope to the resident or a blood pressure cuff. She documented that she observed the other nurses (LPN A and RN C) and the resident. She documented she saw Resident #1 twitching and verified through conversations with the nurses (A and C) that Resident #1 had a history of [REDACTED].#1's record to confirm a history of [MEDICAL CONDITION]. After confirming the [MEDICAL CONDITION] history, she reminded LPN A and RN C to call the physician, then she went to her office, leaving the other two nurses to continue assessing the resident. RN B stated that once she reached her office, she called the Medical Director's Clinical Nurse Liaison (CNL) about another matter. While she was speaking with the CNL, she called out to LPN A and RN C, asking whether the physician had been called. They had not called Resident #1's physician, so RN B mentioned the resident's condition to the CNL during the call. The CNL stated, She should go ahead and go out. She will probably need an IV (intravenous administration) of [MEDICATION NAME]. If the resident is having [MEDICAL CONDITION] it would be a risk to give her anything by mouth. A photograph of a text message sent by Employee B to the CNL on [DATE] at 3:54 PM revealed, Hey, (Resident #1) isn't responding to painful stimuli, she's lethargic and (Nurses A and C) are still assessing her. I am in here now. The CNL replied, If she is unresponsive, send her out. RN B messaged, (Resident #1) is not unresponsive, just lethargic, but staff are in there now. As part of the facility's investigation, a [DATE] facility-initiated interview (time unrecorded) was conducted with RN B. She was asked how she assessed Resident #1. She replied that she just visualized her. In the same interview it was recorded that RN B stated she thought Resident #1 was stable, and she asked Nurses A and C if the resident would be sent out emergently via 911. Nurses A and C replied, No, the resident was stable, so RN B returned to her office. As she was preparing to leave the facility for the day, RN B overheard LPN A tell RN C, If transport does not arrive in an hour, call 911. RN B then left the facility. During a [DATE] interview with RN B at 10:50 AM, she was asked how she determined that Resident #1 was stable on [DATE] before she left for the day. She replied that she visualized her. When asked whether a respiratory rate of ,[DATE] was normal or stable, RN B did not answer. In a written, signed statement dated [DATE], LPN A documented that at 4:00 PM on [DATE], she was called to Resident #1's room by RN C. There she found Resident #1 with an elevated temperature and not responding to a rigorous sternal rub (Using the knuckles of a closed fist to rub the center chest of a patient who is not alert and does not respond to verbal stimuli. Source - EMS1.com at www.ems1.com, accessed on [DATE] at 11:56 AM). LPN A also described the resident as twitching with abnormal vital signs including a BP

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 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) ,[DATE] (blood pressure, mmHg), P63 (pulse), RR26 (respiratory rate), Temp 99 degrees Fahrenheit (F), Oxygen Saturation (O2sats) of 89% and mouth breathing. In an undated and untimed statement made during the facility's investigation, LPN A documented that she informed the resident's relative of possible [MEDICAL CONDITION] and non-therapeutic [MEDICATION NAME] levels. A call was placed to a non-emergency transport company, but they were unavailable, so a second call was placed to another non-emergency transport company, who informed LPN A that there would be a one-hour wait. LPN A then left the facility. RN C recorded in his written statement, dated [DATE], a timeline of events and actions that were taken by him on [DATE] as follows: On [DATE] at 4:00 PM - (Resident #1's) respirations were 26. She was receiving oxygen at 2 liters per minute via nasal cannula. On [DATE] at 5:00 PM - Rechecked resident, no signs of pain or distress noted, RR25, oxygen at 2 liters per minute, resident stable, will continue to monitor. On [DATE] at 5:30 PM - No twitching, but RR25 and resident continues on oxygen at 2 liters to keep her sats (blood oxygen saturation) at 97%. Resident stable, will continue to monitor. On [DATE] at 6:00 PM - Temp 99.3 F, RR26, continues on oxygen at 2 liters per minute to keep her oxygen saturation at 97%. Resident stable, will continue to monitor. On [DATE] at 6:30 PM - No twitching, RR25, resident continues on oxygen at 2 liters per minute to help maintain her saturation of 97%. Resident stable, continue to monitor closely. On [DATE] at 7:00 PM - No twitching, RR25, continues on oxygen at 2 liters per minute. Stable, will continue to monitor closely. On [DATE] at 7:30 PM - No twitching, RR25, continues on oxygen at 2 liters per minute. Stable, will continue to monitor closely. On [DATE] at 8:00 PM - No twitching, RR25, continues on oxygen at 2 liters per minute to maintain her saturation at 97%. Called the non-emergency transport company again and they stated they would be available in 2 hours. Will continue to monitor closely. On [DATE] at 8:30 PM - Respiratory rate increased to RR26, (Resident#1} still requires oxygen at 2 liters per minute to maintain oxygen sats of 97%. Resident stable, continue to monitor. On [DATE] at 9:00 PM - RR26 breaths per minute. Continues to require oxygen at 2 liters per minute to maintain her sats at 97%. Stable, continue to monitor. On [DATE] at 9:30 PM - RR27 breaths per minute, oxygen saturation 94 %. Stable, will continue to monitor closely. On [DATE] at 10:00 PM - Called non-emergency transport, and they reported they would probably arrive at midnight or 1:00 AM. Went to the resident's room to recheck (Resident #1) and found the resident using accessory muscles to breathe. Asked another nurse (not identified in his note) to call 911. Monitored the resident at her bedside and at 10:14 PM, he documented that Resident #1 had a respiratory arrest and a code blue was called. A review of the facility's Code Blue worksheet revealed that on [DATE] at 10:14 PM, Resident #1 became unconscious. Cardiopulmonary resuscitation (CPR) was started at 10:14 PM. Emergency Medical Services arrived at 10:20 PM, took over CPR and transported the resident to the ER at 10:30 PM. Resident #1 did not survive. A review of the facility's policy for addressing a change in a resident's condition, revealed no instructions prioritizing or utilizing 911 in emergency situations, or when a resident experienced an acute change in condition, rather than non-emergency transportation. A review was conducted of the policy titled: Standard Notification of Resident/Patient Change in Condition (effective February 2020) from the clinical guidelines manual 5.1.1 page 1 of 1: Procedure - 1. Notify physician, resident/resident representative and case management when indicated, if there is a significant change in condition, regardless of the time of day. M. If the nurse responsible for the care of the resident is remaining with the resident and is unable to place the call, another nurse will place the call. A review was conducted of the Policy and Procedure titled: Topic Significant Change in Resident Status ([DATE]) Manual 5.3.1, page 1 of 1: 1.Staff will monitor for significant change in the resident's status and notify resident physician. Procedure - 1. Significant change is one of the following: a. Deterioration in 2 or more activities of daily living b. Change in the ability to walk or transfer c. Change in the ability to use one's hands or grasp small objects d. Deterioration in behavior or mood to the point where daily problems arise or relationships become problematic e. Deterioration in health status that is permanent f. No response by the resident to the treatment for [REDACTED]. Threat to life such as stroke, heart condition or [MEDICAL CONDITION] i. A new [DIAGNOSES REDACTED]. j. Improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed. k. New onset of impaired decision making l. Continence to incontinence or indwelling catheter m. Use of a restraint when it was never used before. During a [DATE] interview with the Director of Nursing (DON) at 2:42 PM, she was asked to clarify what no response to pain stimulation meant. She stated it meant the resident was not responsive. When asked what the significance of a respiratory rate of 25 - 27 was, she replied it meant the resident was in distress. When asked for her expectation of the nursing staff on [DATE] between 3:30 PM and 10:14 PM regarding Resident #1, she stated, They should have just sent her out 911. When the resident's care plan for [MEDICAL CONDITION] activity was reviewed with the DON, noting that during [MEDICAL CONDITION] activity the staff should document the [MEDICAL CONDITION] location, activity and level of consciousness after [MEDICAL CONDITION] activity, the DON confirmed that no documentation was available verifying this was done for Resident #1 on [DATE]. During a [DATE] interview with CNL at 11:02 AM, she verified that RN B called her on [DATE] (time not remembered) and reported that Resident #1 was not herself, respirations were up, the resident was twitching and staff were unable to get an oxygen saturation reading, because the resident's hands were twitching and jerking. She stated she asked RN B about the resident's [MEDICAL CONDITION] medication and whether she had received it the night before ([DATE]). RN B stated the resident had not received the correct dosage. The CNL stated she advised RN B that the resident would need to go to the hospital. She reached out to the resident's physician who also said, Send her to the hospital. She stated the expectation was that the facility would summons emergency transport for any respirations over 20, as this would be considered respiratory distress, especially for this resident with a typical RR of ,[DATE] per minute. When asked for her expectation of what would happen to a resident in respiratory distress for an extended period of time, she replied, I would expect them to die. During a [DATE] interview with the resident's physician at 11:36 AM, he was asked to recount what he recalled of the events of [DATE] related to Resident #1. He reported he remembered that Resident #1 had problems with her [MEDICATION NAME] level being low, so he increased her medication. When he learned that the resident was having a [MEDICAL CONDITION], he said he stated, This is not something we're going to mess with, especially in a nursing home where bad things do happen. He stated he asked that the resident be sent to the hospital and then, When I say to send the resident to the hospital, I mean go now. When asked about Resident #1's RR of ,[DATE] and the expected result of a prolonged period of respiratory distress, he stated, Bad stuff happens when someone is in distress. Sometimes someone can hang in there for a while, but they need a higher level of care, so they need to be sent to the ER immediately. In a [DATE] interview with the DON at 2:04 PM, she stated that RN C did not use the best clinical judgement. She further stated that respirations of ,[DATE] were not normal for any resident and required emergency intervention. She added that she could not understand why RN C did not call her for guidance. During a [DATE] interview with the Administrator at 5:00 PM, he was asked how the facility confirmed the resident's cause of death. He stated, Anytime a resident has a hospitalization or death, the very next day we call the hospital to determine the circumstances and to request a death certificate. He stated the facility called the hospital on [DATE] at 8:00 AM and they were notified that the resident died from cardiac failure. They requested a death certificate for Resident #1, and were told the hospital thought the physician had it. He would ask the physician to send it to the facility. No death certificate was provided for review. The administrator stated that the delay in provision of care and transportation to a higher level of care should never have happened. A review of an article titled: Help for [MEDICAL CONDITION] at the website www.dignityhealth.org revealed: Call 911 or seek emergency medical help for [MEDICAL CONDITION] if: Someone experiences a [MEDICAL CONDITION] for the first time. A person sustains an injury or experiences other serious symptoms such as trouble breathing. According to www.nursingcenter.com: Lippincott Nursing Center: Guide to Care for Patients: Managing [MEDICAL CONDITION], Source: The Nurse Practitioner (May2007 - Volume:32, Number5, Page,[DATE]: Basic First Aid for [MEDICAL CONDITION]: Call Emergency Medical Services (911) if the person has difficulty breathing or is not breathing or has a known heart condition. Monitor and note information about the [MEDICAL CONDITION], including the time the [MEDICAL CONDITION] began, stopped and body movements during the [MEDICAL CONDITION]. According to www.timeofcare.com: Time of Care Online Medicine Notebook. Respiratory Distress, Failure, Arrest: Respiratory distress is a condition of abnormal respiratory rate or effort . Respiratory distress includes increased work of breathing Respiratory distress leads to [MEDICAL CONDITION]. According to www.acls.com: Managing respiratory arrest: Respiratory arrest is usually the end point of respiratory distress that leads to [MEDICAL CONDITION]. Respiratory distress and failure may have multiple causes, all of which left untreated, can deteriorate into respiratory arrest. Regardless of the cause, respiratory arrest is a life-threatening situation that requires immediate management. According to www.verywellhealth.com: Differences between respiratory arrest and [MEDICAL CONDITION] by Rod Brouhard EMT-P (updated February 8, 2020): Respiratory arrest leads to [MEDICAL CONDITION]. These two conditions are absolutely linked. Respiratory arrest will always lead to [MEDICAL CONDITION] if nothing is done to treat it. According to www.healthline.com: What is Acute [MEDICAL CONDITION]? Written by Brindles Lee Macon and Winnie Yu (updated on [DATE]): [MEDICAL CONDITION] happens when the capillary or tiny blood vessels surrounding the lung air sacs

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F 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) cannot properly exchange carbon [MEDICATION NAME] for oxygen. With acute [MEDICAL CONDITION] you experience immediate symptoms from not having enough oxygen in the body. In most cases this failure may lead to death if it's not treated quickly. According to www.merckmanuals.com: Overview of Respiratory Arrest by Vanessa Moll, MD, DESA, Emory University School of Medicine (last review [DATE]): Respiratory arrest and [MEDICAL CONDITION] are distinct, but inevitably, if untreated, one leads to the other. Throughout the survey, the facility provided their immediate actions to remove IJ, and these immediate actions were verified as having been completed by the survey team as follows: On [DATE], the facility suspended LPN A, RN B and RN C pending investigation. On [DATE], the Regional Director of Risk Management initiated an investigation, interviewing and collecting written statements from Nurses A, B and C. On [DATE], the DON and the Staff Development Coordinator (SDC) assessed all residents in the facility for any change of condition. On [DATE], the facility conducted an ad hoc Quality Assurance Performance Improvement (QAPI) meeting which included the Medical Director. A training and education plan for the facility was developed and approved by the committee. On the same day, the facility submitted a five-day federal report for abuse and neglect. On [DATE], the DON completed an audit of all residents receiving [MEDICAL CONDITION] medication for change in condition/[MEDICAL CONDITION] activity, and ensured that those residents had routine and physician-reviewed laboratory testing for medication levels. On [DATE], the SDC and the DON initiated abuse, neglect and exploitation training for all staff and change-in-condition training for all nurses. As of [DATE], 97% (two nurses were still out on sick leave, one was on family leave and two nurses were suspended) of nurses were re-educated by the DON on the protocol for change of condition. Education included: * Utilize 911 EMS service following MD orders to transfer to hospital due to change in condition. * Complete change of condition E-Interact form for identified change of condition. * Understand the need for immediate intervention when residents present with: Change in level of consciousness to include residents who are typically difficult to arouse and who are now unarousable. Elevated respiration rate that does not quickly resolve due to risk for [MEDICAL CONDITION]/fatigue. On [DATE], RN C was terminated and on [DATE], he was reported to the Florida Board of Nursing. On [DATE] and [DATE], the facility performed a 14-day look-back audit for all residents sent to the hospital to validate the timeliness of intervention and transfer. This was confirmed through review of the audits. Ten residents were reviewed, and no concerns were identified related to the timelines of intervention and transfer to hospital. On [DATE] at 9:30 AM, a review of the facility's education records confirmed that 28 nurses (97%) received the in-service training. On [DATE] at 3:30 PM, nurses E, F, G, H, I and J were interviewed by the survey team about the training received. They were each able to recall the training and appropriately answer questions about how they should respond in a similar situation. During a [DATE] interview with the Administrator at 2:30 PM, he stated the facility would continue to conduct on-going audits three times weekly for four weeks then as indicated by the QA&A compliance committee. .
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to provide treatment and care based on the comprehensive assessment of a resident and in accordance with professional standards of practice, by failing to appropriately assess the resident's condition and transfer them to a higher level of care as ordered by the physician for one (Resident #1) of three sampled residents who experienced an acute change in condition. The facility staff delayed Resident #1's hospital transfer for six hours, until she went into [MEDICAL CONDITION]. After attempted resuscitation and hospital transfer, she later died . This also placed the facility's 103 other current residents at risk of not receiving appropriate care following an acute change in condition. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 3:00 p.m. on [DATE]. On [DATE] at 3:30 p.m., the Immediate Jeopardy (IJ) began. Throughout the survey, the facility provided their immediate actions to remove IJ, and these immediate actions were verified as having been completed by the survey team. On [DATE] at 6:50 p.m., the Administrator was notified of the IJ determination, and immediate jeopardy was removed at the time of survey exit on [DATE] at 7:00 PM. The facility remained out of compliance, and the scope and severity were reduced to a D. The findings include: Cross reference to F658. A review of Resident #1's clinical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. The resident had documented wishes to be resuscitated in the event of a [MEDICAL CONDITION] (full code). A review of the resident's most recent Minimum Data Set (MDS) assessment (quarterly), with an assessment reference date of [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 possible points, indicating severe cognitive impairment. The resident required extensive assistance of one staff member with most activities of daily living (ADLs), except for meals, for which she only required supervision. Further review of the clinical record revealed that from the date of admission on [DATE] through [DATE], the resident had not experienced any [MEDICAL CONDITION]-type activity. A review of Resident #1's respiratory record history from [DATE] through [DATE], revealed her average respiratory rate (RR) was ,[DATE] breaths per minute. A review of the [DATE] physician's orders [REDACTED]. A review of the resident's lab work showed that on [DATE], blood was drawn for a therapeutic level of [MEDICATION NAME], revealing suboptimal concentrations of the medication and a [MEDICATION NAME] level of 6.7 ug/ml (micrograms per milliliter). The normal range was noted as ,[DATE] ug/ml. This left Resident #1 more susceptible to [MEDICAL CONDITION] activity, and the resident's physician increased her [MEDICATION NAME] dosage from 100 mg twice daily to 300 mg at bedtime on [DATE]. In LPN A's nursing progress note dated [DATE] at 4:44 PM, she documented that she went to assess the resident with the two other nurses (RN B and RN C), and the resident's oxygen saturation dropped to 89% on room air with a RR of 26. The resident was rechecked and had a temperature of 99.2 degrees Fahrenheit (F) and RR 26 with slight twitching from head to toe. She noted that Resident #1 was placed on oxygen via face mask at 10 liters per minute and the oxygen saturation came up to 99%. A review of Resident #1's current physician's orders [REDACTED]. In LPN A's nursing progress note dated [DATE] at 4:54 PM, she documented that a telephone order was received from the physician instructing staff to, Send resident to ER for [MEDICAL CONDITION]/uncontrolled [MEDICATION NAME] levels. Based on a review of the resident's clinical record and a review of the facility's investigation documentation, on [DATE], Employee A, Licensed Practical Nurse (LPN), was working the day shift (7AM - 3PM) providing care on the unit where Resident #1 lived. Employee B, Registered Nurse (RN), was also working on that shift, and at 3:00 PM, Employee C, RN, came on duty to work the evening shift (3PM - 11PM) and to care for Resident #1. In a written statement, dated [DATE] at 3:30 PM, RN C wrote that during change of shift rounds, he found Resident #1 with a respiratory rate (RR) of 26, twitching activity, and she was not responding to painful stimulation. He documented that oxygen was started at 2 liters per minute. He called LPN A and RN B to assess the resident and documented that an order was received from the physician to send the resident to the emergency room (ER) for evaluation. In a written statement, dated [DATE], RN B recorded that she had been called to Resident #1's room to take a look at the resident, but at no time did she put a stethoscope to the resident or a blood pressure cuff. She documented that she observed the other nurses (LPN A and RN C) and the resident. She documented she saw Resident #1 twitching and verified through conversations with the nurses (A and C) that Resident #1 had a history of [REDACTED].#1's record to confirm a history of [MEDICAL CONDITION]. After confirming the [MEDICAL CONDITION] history, she reminded LPN A and RN C to call the physician, then she went to her office, leaving the other two nurses to continue assessing the resident. RN B stated that once she reached her office, she called the Medical Director's Clinical Nurse Liaison (CNL) about another matter. While she was speaking with the CNL, she called out to LPN A and RN C, asking whether the physician had been called. They had not called Resident #1's physician, so RN B mentioned the resident's condition to the CNL during the call. The CNL stated, She should go ahead and go out. She will probably need an IV (intravenous administration) of [MEDICATION NAME]. If the resident is having [MEDICAL CONDITION] it would be a risk to give her anything by mouth. A photograph of a text message sent by Employee B to the CNL on [DATE] at 3:54 PM revealed, Hey, (Resident #1) isn't responding to painful stimuli, she's lethargic and (Nurses A and C) are still assessing her. I am in here now. The CNL replied, If she is unresponsive, send her out. RN B messaged, (Resident #1) is not unresponsive, just lethargic, but staff are in there now. As part of the facility's investigation, a [DATE] facility-initiated interview (time unrecorded) was conducted with RN B. She was asked how she assessed Resident #1. She replied that she just visualized her. In the same interview it was recorded that RN B stated she thought Resident #1 was stable, and she asked Nurses A and C if the resident would be sent out emergently via 911. Nurses A and C replied, No, the resident was stable, so RN B returned to her office. As she was preparing to leave the facility for the day, RN B overheard LPN A tell RN C, If transport does not arrive in an hour, call 911. RN B then left the facility. During a [DATE] interview with RN B at 10:50 AM, she was asked how she

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) determined that Resident #1 was stable on [DATE] before she left for the day. She replied that she visualized her. When asked whether a respiratory rate of ,[DATE] was normal or stable, RN B did not answer. In a written, signed statement dated [DATE], LPN A documented that at 4:00 PM on [DATE], she was called to Resident #1's room by RN C. There she found Resident #1 with an elevated temperature and not responding to a rigorous sternal rub (Using the knuckles of a closed fist to rub the center chest of a patient who is not alert and does not respond to verbal stimuli. Source - EMS1.com at www.ems1.com, accessed on [DATE] at 11:56 AM). LPN A also described the resident as twitching with abnormal vital signs including a BP ,[DATE] (blood pressure, mmHg), P63 (pulse), RR26 (respiratory rate), Temp 99 degrees Fahrenheit (F), Oxygen Saturation (O2sats) of 89% and mouth breathing. In an undated and untimed statement made during the facility's investigation, LPN A documented that she informed the resident's relative of possible [MEDICAL CONDITION] and non-therapeutic [MEDICATION NAME] levels. A call was placed to a non-emergency transport company, but they were unavailable, so a second call was placed to another non-emergency transport company, who informed LPN A that there would be a one-hour wait. LPN A then left the facility. RN C recorded in his written statement, dated [DATE], a timeline of events and actions that were taken by him on [DATE] as follows: On [DATE] at 4:00 PM - (Resident #1's) respirations were 26. She was receiving oxygen at 2 liters per minute via nasal cannula. On [DATE] at 5:00 PM - Rechecked resident, no signs of pain or distress noted, RR25, oxygen at 2 liters per minute, resident stable, will continue to monitor. On [DATE] at 5:30 PM - No twitching, but RR25 and resident continues on oxygen at 2 liters to keep her sats (blood oxygen saturation) at 97%. Resident stable, will continue to monitor. On [DATE] at 6:00 PM - Temp 99.3 F, RR26, continues on oxygen at 2 liters per minute to keep her oxygen saturation at 97%. Resident stable, will continue to monitor. On [DATE] at 6:30 PM - No twitching, RR25, resident continues on oxygen at 2 liters per minute to help maintain her saturation of 97%. Resident stable, continue to monitor closely. On [DATE] at 7:00 PM - No twitching, RR25, continues on oxygen at 2 liters per minute. Stable, will continue to monitor closely. On [DATE] at 7:30 PM - No twitching, RR25, continues on oxygen at 2 liters per minute. Stable, will continue to monitor closely. On [DATE] at 8:00 PM - No twitching, RR25, continues on oxygen at 2 liters per minute to maintain her saturation at 97%. Called the non-emergency transport company again and they stated they would be available in 2 hours. Will continue to monitor closely. On [DATE] at 8:30 PM - Respiratory rate increased to RR26, (Resident#1} still requires oxygen at 2 liters per minute to maintain oxygen sats of 97%. Resident stable, continue to monitor. On [DATE] at 9:00 PM - RR26 breaths per minute. Continues to require oxygen at 2 liters per minute to maintain her sats at 97%. Stable, continue to monitor. On [DATE] at 9:30 PM - RR27 breaths per minute, oxygen saturation 94 %. Stable, will continue to monitor closely. On [DATE] at 10:00 PM - Called non-emergency transport, and they reported they would probably arrive at midnight or 1:00 AM. Went to the resident's room to recheck (Resident #1) and found the resident using accessory muscles to breathe. Asked another nurse (not identified in his note) to call 911. Monitored the resident at her bedside and at 10:14 PM, he documented that Resident #1 had a respiratory arrest and a code blue was called. A review of the facility's Code Blue worksheet revealed that on [DATE] at 10:14 PM, Resident #1 became unconscious. Cardiopulmonary resuscitation (CPR) was started at 10:14 PM. Emergency Medical Services arrived at 10:20 PM, took over CPR and transported the resident to the ER at 10:30 PM. Resident #1 did not survive. A review of the facility's policy for addressing a change in a resident's condition, revealed no instructions prioritizing or utilizing 911 in emergency situations, or when a resident experienced an acute change in condition, rather than non-emergency transportation. A review was conducted of the policy titled: Standard Notification of Resident/Patient Change in Condition (effective February 2020) from the clinical guidelines manual 5.1.1 page 1 of 1: Procedure - 1. Notify physician, resident/resident representative and case management when indicated, if there is a significant change in condition, regardless of the time of day. M. If the nurse responsible for the care of the resident is remaining with the resident and is unable to place the call, another nurse will place the call. A review was conducted of the Policy and Procedure titled: Topic Significant Change in Resident Status ([DATE]) Manual 5.3.1, page 1 of 1: 1.Staff will monitor for significant change in the resident's status and notify resident physician. Procedure - 1. Significant change is one of the following: a. Deterioration in 2 or more activities of daily living b. Change in the ability to walk or transfer c. Change in the ability to use one's hands or grasp small objects d. Deterioration in behavior or mood to the point where daily problems arise or relationships become problematic e. Deterioration in health status that is permanent f. No response by the resident to the treatment for [REDACTED]. Threat to life such as stroke, heart condition or [MEDICAL CONDITION] i. A new [DIAGNOSES REDACTED]. j. Improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed. k. New onset of impaired decision making l. Continence to incontinence or indwelling catheter m. Use of a restraint when it was never used before. During a [DATE] interview with the Director of Nursing (DON) at 2:42 PM, she was asked to clarify what no response to pain stimulation meant. She stated it meant the resident was not responsive. When asked what the significance of a respiratory rate of 25 - 27 was, she replied it meant the resident was in distress. When asked for her expectation of the nursing staff on [DATE] between 3:30 PM and 10:14 PM regarding Resident #1, she stated, They should have just sent her out 911. When the resident's care plan for [MEDICAL CONDITION] activity was reviewed with the DON, noting that during [MEDICAL CONDITION] activity the staff should document the [MEDICAL CONDITION] location, activity and level of consciousness after [MEDICAL CONDITION] activity, the DON confirmed that no documentation was available verifying this was done for Resident #1 on [DATE]. During a [DATE] interview with CNL at 11:02 AM, she verified that RN B called her on [DATE] (time not remembered) and reported that Resident #1 was not herself, respirations were up, the resident was twitching and staff were unable to get an oxygen saturation reading, because the resident's hands were twitching and jerking. She stated she asked RN B about the resident's [MEDICAL CONDITION] medication and whether she had received it the night before ([DATE]). RN B stated the resident had not received the correct dosage. The CNL stated she advised RN B that the resident would need to go to the hospital. She reached out to the resident's physician who also said, Send her to the hospital. She stated the expectation was that the facility would summons emergency transport for any respirations over 20, as this would be considered respiratory distress, especially for this resident with a typical RR of ,[DATE] per minute. When asked for her expectation of what would happen to a resident in respiratory distress for an extended period of time, she replied, I would expect them to die. During a [DATE] interview with the resident's physician at 11:36 AM, he was asked to recount what he recalled of the events of [DATE] related to Resident #1. He reported he remembered that Resident #1 had problems with her [MEDICATION NAME] level being low, so he increased her medication. When he learned that the resident was having a [MEDICAL CONDITION], he said he stated, This is not something we're going to mess with, especially in a nursing home where bad things do happen. He stated he asked that the resident be sent to the hospital and then, When I say to send the resident to the hospital, I mean go now. When asked about Resident #1's RR of ,[DATE] and the expected result of a prolonged period of respiratory distress, he stated, Bad stuff happens when someone is in distress. Sometimes someone can hang in there for a while, but they need a higher level of care, so they need to be sent to the ER immediately. In a [DATE] interview with the DON at 2:04 PM, she stated that RN C did not use the best clinical judgement. She further stated that respirations of ,[DATE] were not normal for any resident and required emergency intervention. She added that she could not understand why RN C did not call her for guidance. During a [DATE] interview with the Administrator at 5:00 PM, he was asked how the facility confirmed the resident's cause of death. He stated, Anytime a resident has a hospitalization or death, the very next day we call the hospital to determine the circumstances and to request a death certificate. He stated the facility called the hospital on [DATE] at 8:00 AM and they were notified that the resident died from cardiac failure. They requested a death certificate for Resident #1, and were told the hospital thought the physician had it. He would ask the physician to send it to the facility. No death certificate was provided for review. The administrator stated that the delay in provision of care and transportation to a higher level of care should never have happened. Throughout the survey, the facility provided their immediate actions to remove IJ, and these immediate actions were verified as having been completed by the survey team as follows: On [DATE], the facility suspended LPN A, RN B and RN C pending investigation. On [DATE], the Regional Director of Risk Management initiated an investigation, interviewing and collecting written statements from Nurses A, B and C. On [DATE], the DON and the Staff Development Coordinator (SDC) assessed all residents in the facility for any change of condition. On [DATE], the facility conducted an ad hoc Quality Assurance Performance Improvement (QAPI) meeting which included the Medical Director. A training and education plan for the facility was developed and approved by the committee. On the same day, the facility submitted a five-day federal report for abuse and neglect. On [DATE], the DON completed an audit of all residents receiving [MEDICAL CONDITION] medication for change in condition/[MEDICAL CONDITION] activity, and ensured that those residents had routine and physician-reviewed laboratory testing for medication levels. On [DATE], the SDC and the DON initiated abuse, neglect and exploitation training for all staff and change-in-condition training for all nurses. As of [DATE], 97% (two nurses were still out on sick leave, one was on family leave and two nurses were suspended) of nurses were re-educated by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105533	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENTS PARK OF JACKSONVILLE	**8700 A C SKINNER PARKWAY JACKSONVILLE, FL 32256**

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) the DON on the protocol for change of condition. Education included: * Utilize 911 EMS service following MD orders to transfer to hospital due to change in condition. * Complete change of condition E-Interact form for identified change of condition. * Understand the need for immediate intervention when residents present with: Change in level of consciousness to include residents who are typically difficult to arouse and who are now unarousable. Elevated respiration rate that does not quickly resolve due to risk for [MEDICAL CONDITION]/fatigue. On [DATE], RN C was terminated and on [DATE], he was reported to the Florida Board of Nursing. On [DATE] and [DATE], the facility performed a 14-day look-back audit for all residents sent to the hospital to validate the timeliness of intervention and transfer. This was confirmed through review of the audits. Ten residents were reviewed, and no concerns were identified related to the timelines of intervention and transfer to hospital. On [DATE] at 9:30 AM, a review of the facility's education records confirmed that 28 nurses (97%) received the in-service training. On [DATE] at 3:30 PM, nurses E, F, G, H, I and J were interviewed by the survey team about the training received. They were each able to recall the training and appropriately answer questions about how they should respond in a similar situation. During a [DATE] interview with the Administrator at 2:30 PM, he stated the facility would continue to conduct on-going audits three times weekly for four weeks then as indicated by the QA&A compliance committee. .