STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105584	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARASOTA MEMORIAL NURSING AND REHABILITATION CENTE	**5640 RAND BLVD SARASOTA, FL 34238**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to honor a legally executed Do No Resuscitate Order (DNR) for 1 (Resident #1) out of 11 residents reviewed for advanced directives. The facility's electronic medical records listed the Resident #1's code status as DNR, and there was a valid DNR order at the time of admission. The facility failed to follow its own policy and procedure. The DNR form was not put in the advance directive book. Staff were unable to find a copy of the resident's DNR, and started Cardiopulmonary Resuscitation (CPR) against the resident's advance directive. The resident received approximately 10 minutes of attempted resuscitation (CPR). The facility's actions to perform CPR against the resident's wishes could have resulted in the resident experiencing severe pain, broken ribs, internal bleeding, aspiration pneumonia, organ damage, permanent brain damage, or coma. If the resident was resuscitated, this could result in undesired intubation (a tube inserted through the mouth to assist with breathing), mechanical ventilation, a prolonged dying process and deprive the resident of a natural death. This action resulted in an Immediate Jeopardy level deficiency. The facility self identified the deficient practice. The facility filed an Adverse Incident Report which detailed the steps the facility took to ensure compliance, and to prevent this type of incident from reoccurring. The facility operationalized the action plan to correct the deficient practice. The deficient practice was corrected [DATE] making it past noncompliance Immediate Jeopardy. The findings included: Facility policy title: Do Not Resuscitate Order Effective [DATE] (reviewed [DATE], [DATE]) and reviewed [DATE] after the death of Resident #1 shows: Policy: Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a DO NOT RESUSCITATE ORDER (DNR) in effect. Procedure: 1. Do Not Resuscitate orders must be signed by the residents attending physician and resident on the Goldenrod DNR form, the form is kept on the unit assigned to the resident in a green book on the desk. 2. A Do Not Resuscitate Order is placed in the EMR (Electronic Medical Record). An icon will appear next to the resident name. The icon in blue and is a heart with a x thru it. The form is signed by the physician and the resident (or resident's legal surrogate, as permitted by state law) (note: use only the state approved DNRO forms) Record review showed on [DATE] Resident #1 was admitted to the facility with a State of Florida Do Not Resuscitate (DNR) Order form. The DNR form was signed by the resident on [DATE]. A current physician order [REDACTED].#1 was unresponsive. She did a sternal rub and but was not able to arouse the resident. Staff A noted a second nurse checked the patients BS (blood sugar) and confirmed it to be within normal range at 126. Two nurses confirmed there was no apical pulse. Supported measures were initiated. When the staff were unable to find the resident DNR form, Emergency Medical Services (EMS) was called and arrived at the facility at 9:23 a.m. A electrocardiogram (EKG) was done and confirmed the resident was in asystole (no heartbeat). The DNR form was found and given to the EMS staff. EMS then discontinued CPR. EMS staff called the time of death at 9:34 a.m. In an interview on [DATE] at 2:33 p.m., Staff C RN said on the day Resident #1 was admitted , the paperwork included a State of Florida DNR Order form. She left the admission paperwork for Staff E LPN to complete. Staff C RN said on [DATE] when the resident was found unresponsive, she tried to locate the DNR order form she saw in the admission paperwork. The form was not in the advanced directive book. After locating the DNR form, she brought it to EMS, and they stopped CPR. Staff C RN said the form was found in the admission packet and had not been placed into the DNR book per facility procedure. In an interview on [DATE] at 2:34 p.m., the Director of Nursing (DON) said Resident #1 received CPR when she had a signed State of Florida DNR Order form and a current physician's orders [REDACTED]. In an interview on [DATE] at 3:07 p.m., Staff A LPN said when alerted by the CNA that Resident #1 was unresponsive, she went to the resident's room. She did a sternal rub and was not able to arouse the resident. She called for assistance, Staff C RN went to check the advance directive book, and then we called for 911. She said she informed EMS Resident #1 was a DNR and the staff was looking for the form. Staff A LPN said they were coding (performed CPR) for about 10 minutes. In an interview on [DATE] at 4:15 p.m., Staff F Social Worker (SW) said the day after Resident #1's admission she went to the chart and checked on her advance directives. She did look in the resident's electronic record and saw a current DNR order. She verified the active DNR order with Resident #1, and the resident said she wished to continue it. Staff F SW said she looked in the advance directive book and did not see a State of Florida DNR Order form for Resident #1, but did not follow through to find out where the DNR form was. In an interview on [DATE] at 12:34 p.m., the DON said the nurse who admits the resident was responsible to ensure advance directive information was in the record. Staff in the admission office, and social service staff were the additional layers to catch a mistake if it happens. There were other things which should have been put in place, but were not found like the admission check list. The admission check list is the form the nurse had to check a box which documented she has seen the DNR form and were it was put. The DNR can be in the chart and in the Advance directives book (DNR book). It was also in the electronic record and on the EMAR (medication administration record). A QAPI comittee meeting was held on [DATE] and a plan of correction was developed. The corrective action started on [DATE], (date of resident death) and was completed on [DATE]. During interview the Administrator and Director of Nursing said all correction action was completed on [DATE] to include the night shift education. The corrective action included a facility wide audit to review all Advanced Directive orders and to ensure DNR forms were placed in the advanced directive book if applicable. The education included code blue drills on all shifts and for all nurses and CNA's. Re-education to all nursing staff and social service staff on the advanced directives procedures and responsibilities. Individual education was provided to the social worker and admitting nurse involved on importance of following established processes and procedures. Facility policies and procedures were reviewed and revised. The Do Not Resuscitate Order policy with effective date of [DATE] (reviewed [DATE] and [DATE], and [DATE]) was reviewed and further revised on [DATE]. The 48 hour baseline care plan assessment template was revised to include more detailed information on advanced directives. The revision of the baseline assessment is now reviewed by the interdisiplinary team and the social worker checks the book for the presence of the DNR form, and documents this step. The corrective actions were completed to ensure compliance, and prevent this type of incident from reoccurring to any existing or future residents. The corrective action plan was completed. The completed action plan was confirmed.

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.