STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105320	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dade City Health and Rehabilitation Center	37135 Coleman Ave Dade City, FL 33525

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 - Actual harm 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** 14161 Based on observations, interviews, and record review, the facility failed to ensure the right to formulate an advance directive was honored for two residents (#109 and #212) out of three residents sampled for Advanced Directives related to a resident receiving CPR (cardiopulmonary resuscitation) for 3 minutes when they had wished to not be resuscitated and a resident without an advance directive order who wished to have one. Findings Included: 1) Resident #109 was admitted to the facility on [DATE] for rehabilitation services after a hospitalization , with diagnoses including chronic kidney disease Stage 3B, acute respiratory failure with hypoxia, and chronic diastolic Congestive Heart Failure. Review of Resident #109's medical record revealed the following: -A State of Florida Do Not Resuscitate form was signed by a physician and a family member of Resident #109 on [DATE]. -The resident was receiving hospice services. -A Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form was signed by a medical provider and completed on [DATE]. The form revealed under Advanced Care Planning a check under yes for Do Not Resuscitate (DNR). -On [DATE] a baseline care plan was developed for Resident #109. Review of the care plan revealed the resident expressed a preference for DNR. The goal was My wishes for code status will be followed through next review date, and an approach to be followed by nursing was documented as Follow Code Status per physician order. -Review of Resident #109's physician order summary report revealed a telephone order, dated [DATE], as DO NOT RESUSCITATE. The order was signed by the physician on [DATE]. (continued on next page)

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

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F 0578 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Staff CC, Certified Nursing Assistant (CNA) on [DATE] at 3:20 p.m. Staff CC stated she had Resident #109 in her assignment on the 11 p.m. to 7 a.m. shift on [DATE]. Staff CC stated she was conducting her rounds and found Resident #109 lying on her side and unresponsive. Staff CC stated she got a nurse (Staff AA) and told the nurse that Resident #109 was unresponsive. She stated Staff AA, Registered Nurse (RN), tried to obtain a response from Resident #109 without success. She stated Staff AA, RN then Called a code. Staff CC stated she asked Staff AA if she was sure as she had overheard a nurse talking about Resident #109 being on hospice and a DNR. Staff CC stated Staff AA told her the last time she had checked Resident #109 was a full code because a signature was needed. Staff CC stated Staff AA called the code over the intercom. Staff CC stated she participated in the resuscitation attempt of Resident #109 until another nurse (Staff DD, Licensed Practical Nurse, LPN) told them Resident #109 had a signed DNR order and Cardiopulmonary Resuscitation (CPR) was stopped. An interview was conducted with Staff DD, LPN on [DATE] at 2:34 p.m. Staff DD stated she was working on the other side of the building when the Code Blue announcement was made, and she came to Resident #109's room. She stated when she arrived at Resident #109's room CPR had already been initiated and she asked if anyone had contacted 911. She stated she was told no one had called 911 so she went to the nurse's station to call. Staff DD stated while she was on the phone with 911, she looked in the electronic medical record on the computer and found Resident #109 had a signed DNR order. She stated she went to Resident #109's room and yelled out the staff performing CPR that Resident #109 had a DNR order. Staff DD stated someone in the room, who was later identified as Staff AA, RN, stated it was a pending order. Staff DD stated she went back to the nurse's station, and she was confused as to why someone was stating it was pending as she could see the signed DNR order and the signed State of Florida Do Not Resuscitate form. She stated she showed the nurse, Staff AA, RN the DNR order and The paper in the code book. She stated Staff AA then went back to room and told the staff to stop CPR. Staff DD, LPN stated, She didn't listen to me when I told her the resident was a DNR, she didn't take my word. Staff DD stated she left it to Staff AA, RN to call the family of Resident #109. An interview was conducted with Staff B, LPN, on [DATE] at 2:07 p.m. Staff B stated she was on the other side of the building when she heard a nurse call for a Code Blue. She stated she went into Resident #109's room and CPR was in progress. She stated she took over the ambu bag. She stated she remembered someone coming and stating Resident #109 was a DNR. She stated she just came into help with CPR that was already in progress and did not find out until after it was in progress the resident had a DNR order. A phone interview was conducted with the Medical Director on [DATE] at 11:35 a.m. The Medical Director stated he was also Resident #109's attending physician and her hospice physician. The Medical Director confirmed Resident #109 was a DNR when she was admitted , and he signed an order for DNR on [DATE]. He stated the facility informed the Nurse Practitioner (NP) of the circumstances and the NP called him immediately and informed him. The Medical Director stated it was a nurse who works at the hospital full time and worked for the facility part time, the nurse said the protocol at the hospital was to start CPR and verify later. The Medical Director stated it was an unfortunate event and should not have happened. Review of a form entitled Record of Death revealed the time of death for Resident #109 was documented as 4:05 a.m. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on [DATE] at 9:30 a.m. The DON stated CPR was performed on Resident #109 for approximately three minutes. She stated the timeline for the event was as follows: 4:00 a.m. on [DATE] Staff CC, CNA found resident unresponsive. 4:01 a.m. Staff CC notified Staff AA, RN that resident was unresponsive. 4:02 a.m. Code was called, simultaneously Staff AA, RN started compressions without checking code status. Staff CC, CNA questioned Staff AA, RN who stated resident was Pending DNR. 4:03 a.m. Staff DD, LPN called 911, noted the DNR, hung up and walked to room to notify Staff AA, RN of DNR. Staff AA, RN insists DNR is pending. 4:05 a.m. Staff DD, LPN notified Staff AA, RN again of DNR and showed her documentation of the DNR. 911 contacted again and Emergency Medical Services (EMS) were already in route. 4:05 a.m. compressions stopped. 4:10 a.m. EMS arrived and pronounced Resident #109 deceased . 2) Review of the record for Resident #212 revealed an admitted [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease with acute exacerbation, acute and chronic respiratory failure unspecified whether hypoxia or hypercapnia. A review of the medical record revealed Resident #212 was legally blind and his family member would sign paperwork for him. Review of the Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form, dated [DATE], revealed it was not checked for DNR. There was no physician order for DNR found in Resident #212's record and no record of discussion with Resident #212 or his family member as to his wishes Advanced Directives or cardiopulmonary resuscitation. An interview was conducted with Resident #212 on [DATE] at 12:59 p.m. He stated, I told them to not touch me, I'm done, that's what the purple bracelet is for, the hospital put it on me. I am a DNR, Do Not Resuscitate. An interview was conducted with Staff F, LPN on [DATE] at 4:40 p.m. Staff F stated, he thought if it was after hours he was supposed to wait until the next day to obtain the physician order for DNR. Staff F stated he flagged the progress note so it would show up on the 24-hour report. Staff F stated, I should have done it then. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the DON on [DATE] at 2:50 p.m. The DON stated when residents come in the admitting nurse evaluates paperwork. She stated the 3008 is the order. She stated the nurse converses with the patient and/or verifies orders with the physician. If the 3008 and a Golden Rod are there they go and verify the wishes. She stated the nurse should be calling the physician. Once the resident expresses their wishes the nurse calls the doctor to get orders and two nurses verify the order. The DON reviewed Resident #212's progress note and stated the physician should have been called. Review of a facility policy entitled Standards and Guidelines: Advance Directives Code Status, with an issue date of ,d+[DATE] revealed the following: Standard: It is the policy of the facility to honor Advance Directives, Code Status and Do Not Resuscitate Orders in accordance with State and Federal Regulations. Definitions: Code Status - Listed in the resident's medical chart. Obtained upon admission and reviewed at least quarterly and/or upon resident/ representative's request. Identifies resident's wishes for medical intervention should the resident's heart stop beating and/or should the resident stop breathing. Full Code: Full code means that if a person's heart stopped beating and/ or they stopped breathing, all resuscitation procedures will be provided to keep them alive. This process can include chest compressions, rescue breathing, and/or defibrillation and is referred to as CPR. Do Not Resuscitate (DNR) - A DNR code status would indicate that the person would not want CPR performed and would be allowed to die naturally if their heart stops beating and/ or they stop breathing. Guidelines: Admission /Readmission: Code status verified upon admission with Resident/Representative by admitting NURSE. Nurse reviews code status with the resident/representative and confirms decision with the attending physician (MD). Full Code: Admitting nurse must obtain an order from physician (MD) Order into [NAME] Click Care (PCC) using AA Code Status: FULL CODE (batch order) Green Full Code sheet initiated with Resident Name and Date Green Full Code Sheet is placed in Code Status Binders at all Nurses' stations. Green Full Code Sheet is filed alphabetically (i.e. last name is [NAME] and form is under S alpha tab) (continued on next page)

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