STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Boca Ciega Bay	1255 Pasadena Ave S, Suite C South Pasadena, FL 33707

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 to resident health or safety 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 observations, interviews, and record review, the facility failed to ensure advanced directive wishes and physician orders were followed for one resident (#1) out of six residents sampled for advanced directives.On [DATE], facility staff initiated cardiac compressions (Use of hands to push down hard and fast to manually pump blood through the heart. The pressure from cardiac compressions commonly causes physical damage including fractured ribs or sternum, bruising, and internal organ injury) on Resident #1 after determining no pulse or respirations. The resident had wishes to not be resuscitated and had a physician order for Do Not Resuscitate (DNR), dated [DATE]. Emergency Medical Services (EMS) were called and paramedics took over compressions. Facility staff informed EMS Resident #1 was a DNR and provided the State of Florida DNR form to the paramedics. Paramedics ceased chest compressions and Resident #1 expired. Cardiac compressions were provided to Resident #1 for approximately twenty minutes. The facility staff failed to honor Resident #1's advanced directive wishes and physician signed DNR order, dated [DATE], which was uploaded into the resident's record. The failure to ensure staff honored Resident #1 advanced directive wishes caused unnecessary physical harm and pain and denied Resident #1 a peaceful death.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #1 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm.Cross reference to F600, F678, and F726.Findings Include: A review of Resident #1's admission record revealed an initial admission to the facility on [DATE], and a re-admission on [DATE] with diagnoses to include myasthenia gravis without (acute) exacerbation, immunodeficiency, unspecified, chronic obstructive pulmonary disease, unspecified, acute pulmonary edema, peripheral vascular disease, unspecified, personal history of transient ischemic attack (tia), cerebral infarction without residual deficits, and adult failure to thrive. A review of Resident #1's physician orders included the following:Do Not Resuscitate (DNR), with an ordered/created date of [DATE] and an end date of [DATE].Do Not Resuscitate (DNR), with an ordered/created date of [DATE] and an end date of [DATE].Full Cardiopulmonary Resuscitation (CPR), with an ordered/created date of [DATE] and an end date of [DATE]. Further review of the order had notes with the following, changed to DNR.Full Cardiopulmonary Resuscitation (CPR), with an ordered/created date of [DATE] and an end date of [DATE]. Further review of the order had notes with the following, Resident is DNR status. The order was created on [DATE] at 3:04 p.m., by Staff A, Licensed Practical Nurse (LPN). The order was discontinued by Staff I, Registered Nurse (RN) on [DATE] at 7:31 a.m. A review of Resident #1's care plan revealed the following: Resident has the capacity to make health care decisions and has signed a DNR Date Initiated: [DATE] Revision on: [DATE], with interventions to include, Placed signed DNR under Advanced Directives tab in the MISC (continued on next page)

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.

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

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[miscellaneous] section of the Electric medical record. Date Initiated: [DATE] Revision on: [DATE]. A review of Resident #1's progress notes revealed the following: [DATE] encounter, .Patient wishes to change his CODE STATUS to DNR. DNR is documented in [hospital name] Type of care preferred: --Patient wishes to be transferred to the hospital in case of medical emergency. --Patient will appoint healthcare surrogate --Patient's family will bring DNR paper but will communicate with social worker to follow.[DATE] nursing note, Notified By Social services that Resident Code Status Updated to DNR. Orders Updated.[DATE] change in condition note at 3:00 p.m., The Change In Condition/s reported . Abnormal vital signs (low/high BP [blood pressure], heart rate, respiratory rate, weight change) Respiratory arrest Shortness of breath At the time of evaluation resident/patient vital signs, weight and blood sugar were: . - Pulse: P 72 - [DATE] 03:12 Pulse Type: Regular - Pulse Oximetry: O2 55 % - [DATE] 15:00 [3:00 p.m.] Method: Oxygen via Nasal Cannula . Code Status: Do Not Resuscitate (DNR) . Nursing observations, evaluation, and recommendations are: hypoxic, transfer to ER [emergency room] . Primary Care Provider responded with the following feedback: A. Recommendations: transfer to ER .[DATE] nursing note at 4:40 p.m., Note Text: 1500 Writer called in to resident room for C/O [complaint of] cough, SOB [shortness of breath], resident noted in bed, awake looking unwell and c/o SOB, vitals measured, hypoxic, SPO2 [oxygen saturation] 55% highest, [Staff G, Nurse Practitioner (NP)] contacted and agrees to send to ER, paramedics arrived, resident expired during workup. Family, [Staff G, Nurse Practitioner] and funeral home contacted. Remains picked up at 1640. [4:40 p.m.] A review of Resident #1's evaluations/assessments revealed the following: [DATE] advance care planning discussion/review, b. readmission . 1. Code status b. Florida Do Not Resuscitate. A review of Resident #1's miscellaneous documents revealed the following:State of Florida DNR order, dated [DATE], with Resident #1 and the physician's signature was scanned into the electronic health record on [DATE] at 3:02 p.mXXX[DATE] inpatient hospitalist progress note, Internal Medicine Inpatient Note . Admission/Discharge [DATE] - Present . Admitting Diagnosis: SEVERE SEPSIS, PNA [pneumonia] . ***CODE STATUS DNR . Nutrition: Continue pureed diet. Patient cannot tolerate thickened liquids. on thin liquids for comfort care. Patient is aware of the risk of aspiration. He does not want PEG [percutaneous endoscopic gastrostomy] tube. NUTRITION REASSESSMENT . [DATE]: . Per inpatient hospitalist progress note dated [DATE], pt has opted to liberalize his diet for quality of life purposes. Pt agreed this date that this is still in line with his current preferences. On [DATE] at 12:03 p.m., an interview was conducted with Staff D, LPN. She said the most recent actual code blue was with Resident #1. She said on [DATE], she overheard a conversation that someone needed a non-rebreather mask. She said she was assisting another resident at the time, and a Certified Nursing Assistant (CNA) told her she was needed on the other side of the facility. She stated it, Made me think something was going on. Staff D, LPN said she went to the long-term care side of the facility and saw a crash cart outside the door of Resident #1's room. She said Staff A, LPN was doing chest compressions. Staff D, LPN said she gave the non-rebreather mask to Staff N, Registered Nurse (RN). She recalled connecting the mask to the oxygen tank, then heard Staff A, LPN say she needed to switch, and Staff D, LPN took over chest compressions. Staff D, LPN said Staff E, LPN relieved her and started doing chest compressions. She said a few minutes later, as Staff E, LPN was doing chest compressions, the paramedics arrived. She said Staff E, LPN continued chest compressions, per the paramedics' advisement, and she left the room. Staff D, LPN said she went to complete the transfer paperwork to include the face sheet, medication list, and transfer to hospital form. She said she noted Resident #1 was not a full code. She stated, When I noted he was a DNR, [Staff E, LPN] and [Staff N, RN] were coming out of the room, paramedics had taken over. Staff D, LPN stated she asked Staff N, RN, Why did we do CPR on a DNR. She said she (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 observations, interviews, and record review, the facility failed to ensure the residents were free from abuse by performing Cardiopulmonary Resuscitation (CPR) against the resident's wishes for one resident (#1) out of six residents sampled for Advance Directives.On [DATE], Resident #1 experienced a change of status when his oxygen saturation levels dropped to 55% (Normal oxygen saturation levels range from 95%-100%). Resident #1 stopped breathing and was without a pulse. The facility staff initiated CPR. Resident #1 had a physician order for Do Not Resuscitate (DNR), dated [DATE]. Cardiac compressions (Use of hands to push down hard and fast to manually pump blood through the heart. The pressure from cardiac compressions commonly causes physical damage including fractured ribs or sternum, bruising, and internal organ injury) were initiated by staff. Emergency Medical Services (EMS) were called and paramedics took over compressions. Facility staff informed EMS Resident #1 was a DNR and provided the documentation to the paramedics. Paramedics discontinued cardiac compressions. Cardiac compressions were provided to Resident #1 for approximately twenty minutes. The CPR provided for Resident #1 against his wishes, denied him the right to a peaceful death and caused unnecessary physical harm and pain.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #1 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm.Cross reference to F578, F678, and F726.Findings Include: A review of Resident #1's admission record revealed an initial admission to the facility on [DATE], and a re-admission on [DATE] with diagnoses to include myasthenia gravis without (acute) exacerbation, immunodeficiency, unspecified, chronic obstructive pulmonary disease, unspecified, acute pulmonary edema, peripheral vascular disease, unspecified, personal history of transient ischemic attack (tia), cerebral infarction without residual deficits, and adult failure to thrive. A review of Resident #1's physician orders included the following: - Do Not Resuscitate (DNR), with an ordered/created date of [DATE] and an end date of [DATE]. - Do Not Resuscitate (DNR), with an ordered/created date of [DATE] and an end date of [DATE]. - Full Cardiopulmonary Resuscitation (CPR), with an ordered/created date of [DATE] and an end date of [DATE]. Further review of the order had notes with the following, changed to DNR. - Full Cardiopulmonary Resuscitation (CPR), with an ordered/created date of [DATE] and an end date of [DATE]. Further review of the order had notes with the following, Resident is DNR status. The order was created on [DATE] at 3:04 p.m., by Staff A, Licensed Practical Nurse (LPN). The order was discontinued by Staff I, Registered Nurse (RN) on [DATE] at 7:31 a.m. A review of Resident #1's care plan revealed the following: - Resident has the capacity to make health care decisions and has signed a DNR Date Initiated: [DATE] Revision on: [DATE], with interventions to include, Placed signed DNR under Advanced Directives tab in the MISC [miscellaneous] section of the Electric medical record. Date Initiated: [DATE] Revision on: [DATE]. A review of Resident #1's progress notes revealed the following: - [DATE] nursing note, PT [patient] received from [hospital name] to room [number] via [by] [vendor name] Ambulance on stretcher. PT alert/oriented x 3 [awake, alert, and oriented by three] able to sign admission documents. PT oriented to room and staff. PT DX [diagnosis] acute cystitis. PT code status full CPR. - [DATE] encounter, .Patient wishes to change his CODE STATUS to DNR. DNR is documented in [hospital name] Type of care preferred: --Patient wishes to be transferred to the hospital in case of medical emergency. --Patient will appoint healthcare surrogate -- Patient's family will bring DNR paper but will communicate with social worker to follow. - [DATE] nursing note, Notified By Social (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	use her nursing judgment, which is to check their code status, call code blue over the intercom, and grab the crash cart if it was appropriate. She confirmed Resident #1 was a DNR. Staff C, RN stated she knew his code status because Resident #1 was her, Customer service resident, and she was present during his care plan meetings and Minimum Data Set (MDS) admission assessments. She said she had not checked his code status that day and, It could have changed. She did not think there were code blue sheets currently and they were not part of the process prior to Resident #1's code blue event. Staff C, RN stated, No, I have not seen that here as far as code blue sheets. On [DATE] at 2:05 p.m., an interview was conducted with the Central Supply/Staffing Coordinator. The Coordinator said on [DATE], she was walking down the hall to go back to her office. She said Staff E, LPN, was coming out of Resident #1's room and told her to get another nurse. The Central Supply/Staffing Coordinator said she told Staff N, RN she was needed in Resident #1's room. She said Staff E, LPN was getting ready to send Resident #1 to the hospital and thought he was on the telephone with emergency services. The Central Supply/Staffing Coordinator said Staff E, LPN did not tell her why he needed a nurse. She said approximately five to ten minutes later, she walked back down the hallway and observed multiple people in Resident #1's room. She said she did not hear code blue being called. She said she assisted with getting Resident #1 off the floor to the bed. She said she recalled Staff A, LPN and Staff N, RN being in the room, as well as paramedics who were getting ready to leave. She said she had never participated in an actual code blue, but her role would be to get the crash cart and/or call emergency services. The Central Supply/Staffing Coordinator initially stated, I can verify code status in the book, but not in the computer. She said to her understanding there was a code status book and code status could also be found in the Kardex. She said she could not confirm if her role was to check the code status book, but she would find out. On [DATE] at 4:29 p.m., an interview was conducted with the Nursing Home Administrator (NHA) regarding the facility's response and investigation related to Resident #1. She said on [DATE] Staff P, CNA answered Resident #1's call light and he expressed feeling shortness of breath (SOB). She said Staff P, CNA told Staff E, LPN who went to check Resident #1's vital signs and determined his oxygen saturation was low. The NHA said Staff E, LPN contacted the provider and received orders to transfer the resident to the hospital. She said Staff E, LPN told the Staffing Coordinator to tell the nurse manager at the time, Staff N, RN, that he was transferring the resident to the hospital. She said Staff N, RN went to Resident #1's room and checked his oxygen saturation twice with the same result, which was 73%. The NHA said Staff N, RN had taken the crash cart to the room with her. She said Staff E, LPN left Resident #1's room to prepare transfer paperwork to include the medication list, face sheet, and the hospital transfer form with the change in condition documented. The NHA said Staff N, RN started suctioning Resident #1 because he was drooling, while suctioning he had agonal breathing [insufficient breathing that sounds like snorting, gasping, or labored breathing, and indicates that someone is suffering from a medical emergency. The person can appear to be choking or having an involuntary gasp reflex.], then stopped breathing. She said Staff A, LPN came into the room, checked Resident #1's pulse, did not find a pulse and Staff N, RN instructed Staff A, LPN and Staff B, CNA to transfer Resident #1 to the floor to start chest compressions. The NHA said Staff D, LPN came into the room and took over chest compressions from Staff A, LPN. She said Staff E, LPN came back to the room, while they were waiting for paramedics, and he took over chest compressions for Staff D, LPN. She said they switched to Staff A, LPN, who was doing the chest compressions when paramedics arrived. The NHA said after the paramedics took over, Staff C, RN had gone to Resident #1's room and left to confirm his code status. The NHA said Staff C, RN heard Staff E, LPN, Staff D, LPN, and Staff N, RN, who were at the nurse's station say, He's a DNR. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	said she told the nurse to call 911 and transfer him to the hospital based on symptoms he was having. Staff G, NP said she did not recall a follow up call after the initial communication with the nurse about sending Resident #1 to the hospital. She stated, Not sure they mentioned chest compressions during call. Staff G, NP said by the standards of care if a resident had signed orders for DNR, then chest compressions should not be started. On [DATE] at 2:31 p.m., an interview was conducted with Staff B, Certified Nursing Assistant (CNA). She said on [DATE] at approximately 3:00 p.m. there was a call light on for Resident #1's room. She said she helped Staff A, LPN move Resident #1 to the floor as instructed by Staff N, RN. Staff B, CNA said it was only her and Staff A, LPN who moved the resident. She said she informed Staff N, RN that CNAs were not allowed to do CPR and left the room. When she left the room, she said she informed one of the Minimum Data Set (MDS) nurses to call 911. A review of the facility policy titled Abuse, Neglect, Exploitation & [and] Misappropriation, revealed the following: Policy . It is the policy of this facility to take appropriate steps to prevent abuse (be it verbal, sexual, physical, or mental), neglect, exploitation and misappropriation and the occurrence of an injury of an unknown source, and to ensure that all alleged violations of Federal and / or State laws are reported immediately to the Administrator, the Risk Manager, the Social Service Director, and The Director of Nursing., .5. Protection . 2) If the suspected perpetrator is an employee, the Administrator or their designee shall place the employee on immediate suspension, pending the outcome of the investigation. c. The DON/designee shall notify the attending physician regarding the alleged violation and findings and document that the physician was notified and follow any orders received. A review of the facility policy titled Nursing Policies- Emergency Care (CPR), revealed the following: Policy . The facility will identify each resident's choice for treatment and care, help the resident to develop advance directives, as desired, and implement appropriate instructions for care that reflect those choices, all in accordance with the facility's ethics decision making policies and procedures, and Florida State law. Prior to the arrival of emergency medical services (EMS), the facility will provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest or respiratory arrest in accordance with the resident's advance directive or Do-Not-Resuscitate (DNR) order., Procedure . 2. The resident or legal representative will be made aware that the resident has the right not to have CPR performed in the event of a cardiac emergency. Should the resident or legal representative request to not have CPR performed in the event of a cardiac emergency, the facility will provide a yellow DO NOT RESUSCITATE form and explain the terms to the resident or legal representative. 3. Once the resident or resident's legal representative and physician, autonomous advanced practice registered nurse or physician assistant have signed the Yellow DNR form, it will serve as the physician order concerning CPR for the resident, . 7. Should a resident experience cardiac emergency, staff will refer to the presence of the yellow form signed by the resident and physician, and/or the physicians order to determine if CPR should be performed. A review of the facility policy titled Admission/Social Services - Advance Directives, revealed the following: .Procedure. 5. Should the resident or legal representative request to not have CPR performed in the event of a cardiac emergency, the facility will provide a yellow DO NOT RESUSCITATE form and explain the terms to the resident or legal representative. Once the resident or resident's legal representative and physician, autonomous advanced practice registered nurse or physician assistant have signed the Yellow DNR form, it will serve as the physician order concerning CPR for the resident. A review of the facility policy titled Admission/Social Services - Advance Directives - Resident's Right to Make Decision, revealed the following: Purpose . The facility respects the resident's or legal representative's right to make medical treatment decisions and be provided the appropriate (continued on next page)

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	105537	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Boca Ciega Bay	1255 Pasadena Ave S, Suite C South Pasadena, FL 33707

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	information as required under State and Federal Rules and Regulations., A review of the facility policy titled Resident Rights, revealed the following: All residents have rights guaranteed to them under Federal and State laws and regulations. This policy is intended to lay the foundation for the resident rights requirements in long-term care facilities. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input. The facility's immediate actions to remove the Immediate Jeopardy included: - Disciplinary action/suspension was initiated for two nurses. RN was terminated and reported to Board of Nursing. - Nurse files were reviewed and it confirmed CPR certification, license, skills checklists and backgrounds were present for 100% of nurses. - Ad hoc [unplanned/spontaneous] quality assurance performance improvement (QAPI) meetings held on [DATE] and [DATE] to discuss concern and correction plan. [DATE] Ad hoc meeting held to review IJ citations. Ad Hoc meeting on [DATE] at 1:06 p.m. to discuss additional education to evaluate and reinforce education previously provided on code status, abuse, neglect, and exploitation (ANE) reviewed, approved a code blue worksheet, reviewed and approved an abuse posttest to reinforce prior education. [DATE] Ad hoc at 4:31 p.m. to review, revise and approve code blue worksheet. - [DATE] Post ad hoc- took revised code blue worksheet to units and initiated review of the worksheet with staff. Anyone can complete the code blue worksheet. - Education 100% of nurses on advance directives, resident right to make a decision and emergency care (CPR) and ANE by [DATE]. New licensed staff were educated on abuse and code status upon hire. - 100%

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NAME OF PROVIDER OR SUPPLIER Springs at Boca Ciega Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 Pasadena Ave S, Suite C South Pasadena, FL 33707	

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety 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 observations, interviews, and record review, the facility failed to honor a Do Not Resuscitate (DNR) order for one resident (#1) out of three residents sampled. Facility staff unnecessarily provided chest compressions for twenty minutes causing physical harm and a traumatic end of life. On [DATE], Resident #1 was found unresponsive by facility staff. Facility staff performed Cardiopulmonary Resuscitation (CPR), including chest compressions, without confirming Resident #1's preferred resuscitation status. The resident had a physician order for DNR, dated [DATE]. Emergency Medical Services (EMS) were called to the facility, and paramedics took over chest compressions. After twenty minutes of CPR, facility staff informed EMS Resident #1 was a DNR and provided the State of Florida DNR form to the paramedics. Paramedics ceased chest compressions and Resident #1 expired. By providing CPR, the facility staff failed to honor Resident #1's advance directive wishes and physician signed DNR form which caused unnecessary physical harm and pain and denied Resident #1 a peaceful death.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #1 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm.Cross reference to F578, F600, and F726.Findings Include: A review of Resident #1's admission record revealed an initial admission to the facility on [DATE], and a re-admission on [DATE] with diagnoses to include myasthenia gravis without (acute) exacerbation, immunodeficiency, unspecified, chronic obstructive pulmonary disease, unspecified, acute pulmonary edema, peripheral vascular disease, unspecified, personal history of transient ischemic attack (tia), cerebral infarction without residual deficits, and adult failure to thrive. A review of Resident #1's physician orders included the following:Do Not Resuscitate (DNR), with an ordered/created date of [DATE] and an end date of [DATE].Do Not Resuscitate (DNR), with an ordered/created date of [DATE] and an end date of [DATE].Full Cardiopulmonary Resuscitation (CPR), with an ordered/created date of [DATE] and an end date of [DATE]. Further review of the order had notes with the following, changed to DNR.Full Cardiopulmonary Resuscitation (CPR), with an ordered/created date of [DATE] and an end date of [DATE]. Further review of the order had notes with the following, Resident is DNR status. The order was created on [DATE] at 3:04 p.m., by Staff A, Licensed Practical Nurse (LPN). The order was discontinued by Staff I, Registered Nurse (RN) on [DATE] at 7:31 a.m. A review of Resident #1's care plan revealed the following: Resident has the capacity to make health care decisions and has signed a DNR Date Initiated: [DATE] Revision on: [DATE], with interventions to include, Placed signed DNR under Advanced Directives tab in the MISC [miscellaneous] section of the Electric medical record. Date Initiated: [DATE] Revision on: [DATE]. A review of Resident #1's progress notes revealed the following:[DATE] encounter, .Patient wishes to change his CODE STATUS to DNR. DNR is documented in [hospital name] Type of care preferred: --Patient wishes to be transferred to the hospital in case of medical emergency. --Patient will appoint healthcare surrogate --Patient's family will bring DNR paper but will communicate with social worker to follow.[DATE] nursing note, Notified By Social services that Resident Code Status Updated to DNR. Orders Updated.[DATE] change in condition note at 3:00 p.m., The Change In Condition/s reported . Abnormal vital signs (low/high BP [blood pressure], heart rate, respiratory rate, weight change) Respiratory arrest Shortness of breath At the time of evaluation resident/patient vital signs, weight and blood sugar were: . - Pulse: P 72 - [DATE] 03:12 Pulse Type: Regular - Pulse Oximetry: O2 55 % - [DATE] 15:00 [3:00 p.m.] Method: Oxygen via Nasal Cannula . Code Status: Do Not (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resuscitate (DNR) . Nursing observations, evaluation, and recommendations are: hypoxic, transfer to ER [emergency room] . Primary Care Provider responded with the following feedback: A. Recommendations: transfer to ER .[DATE] nursing note at 4:40 p.m., Note Text: 1500 Writer called in to resident room for C/O [complaint of] cough, SOB [shortness of breath], resident noted in bed, awake looking unwell and c/o SOB, vitals measured, hypoxic, SPO2 [oxygen saturation] 55% highest, [Staff G, Nurse Practitioner (NP)] contacted and agrees to send to ER, paramedics arrived, resident expired during workup. Family, [Staff G, Nurse Practitioner] and funeral home contacted. Remains picked up at 1640. [4:40 p.m.] A review of Resident #1's evaluations/assessments revealed the following:[DATE] advance care planning discussion/review, a. admission . Resident Physician Ordered Code Status 1. Code status b. Florida Do Not Resuscitate . He said the [hospital name] has his living will and advanced directives.[DATE] advance care planning discussion/review, b. readmission . 1. Code status b. Florida Do Not Resuscitate. A review of Resident #1's miscellaneous documents revealed the following:State of Florida DNR order, dated [DATE], with Resident #1 and the physician's signature was scanned into the electronic health record on [DATE] at 3:02 p.mXXX[DATE] inpatient hospitalist progress note, Internal Medicine Inpatient Note . Admission/Discharge [DATE] - Present . Admitting Diagnosis: SEVERE SEPSIS, PNA [pneumonia] . ***CODE STATUS DNR . Nutrition: Continue pureed diet. Patient cannot tolerate thickened liquids. on thin liquids for comfort care. Patient is aware of the risk of aspiration. He does not want PEG [percutaneous endoscopic gastrostomy] tube. NUTRITION REASSESSMENT . [DATE]: . Per inpatient hospitalist progress note dated [DATE], pt [patient] has opted to liberalize his diet for quality of life purposes. Pt agreed this date that this is still in line with his current preferences. On [DATE] at 12:03 p.m., an interview was conducted with Staff D, LPN. She said the most recent actual code blue was with Resident #1. She said on [DATE], she overheard a conversation that someone needed a non-rebreather mask. She said she was assisting another resident at the time, and a Certified Nursing Assistant (CNA) told her she was needed on the other side of the facility. She stated it, Made me think something was going on. Staff D, LPN said she went to the long-term care side of the facility and saw a crash cart outside the door of Resident #1's room. She said Staff A, LPN was doing chest compressions. Staff D, LPN said she gave the non-rebreather mask to Staff N, Registered Nurse (RN). She recalled connecting the mask to the oxygen tank, then heard Staff A, LPN say she needed to switch, and Staff D, LPN took over chest compressions. Staff D, LPN said Staff E, LPN relieved her and started doing chest compressions. She said a few minutes later, as Staff E, LPN was doing chest compressions, the paramedics arrived. She said Staff E, LPN continued chest compressions, per the paramedics' advisement, and she left the room. Staff D, LPN said she went to complete the transfer paperwork when she noted Resident #1 was not a full code. She stated, When I noted he was a DNR, [Staff E, LPN] and [Staff N, RN] were coming out of the room, paramedics had taken over. Staff D, LPN stated she asked Staff N, RN, Why did we do CPR on a DNR. She stated, They [paramedics] would not stop until they had the physical DNR in hand. Staff D, LPN said she did not know who initiated compressions and assumed someone checked Resident #1's code status. She stated, The nurse was to check the code status, then to initiate or not to initiate. She said the assigned nurse is expected to check the resident's code status. On [DATE] at 12:52 p.m., an interview was conducted with Staff E, LPN. He said the last time there was an actual code blue was about a month ago, and confirmed it was for Resident #1. He said he went into Resident #1's room, observed he was not doing well, and called the provider for orders to transfer him to the hospital. Staff E, LPN confirmed on [DATE] he was Resident #1's assigned nurse. He said after he received orders from Staff G, NP to transfer him to the hospital, he prepared paperwork to include discharge documents, the face sheet, and the medication list. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	He stated, As I was going to my desk someone was getting the crash cart and going to my patient's room. He said he went to Resident #1's room, observed the resident was on the floor, and staff were doing compressions. He said Staff N, RN was in the room and Staff A, LPN was doing chest compressions. Staff E, LPN confirmed himself, Staff A, LPN, Staff D, LPN did chest compressions, and thought Staff N, RN did as well. He confirmed Resident #1 had physician orders for DNR but did not know at the time chest compressions were done. Staff E, LPN said he did not notice the resident was a DNR because it was not on the face sheet. He stated, Someone must have said something about the resident being a DNR. He said when the paramedics arrived, they took over CPR. He stated, By that time it was known he was a DNR, they [paramedics] could not stop until they had the yellow DNR sheet. He said the resident passed away. On [DATE] at 1:23 p.m., an interview was conducted with Staff C, RN. She stated on [DATE] she was in her office and heard a commotion, then responded to Resident #1's room. She said when she arrived there was a crash cart, staff present were suctioning Resident #1, and he was lowered to the ground. Staff C, RN stated the commotion she heard was staff saying, We need help, call 911. She said she observed Staff N, RN suctioning Resident #1, and was leading the code. She said Staff A, LPN started chest compressions, after being instructed by Staff N, RN. She confirmed Resident #1 was a DNR. Staff C, RN stated she knew his code status because Resident #1 was her, Customer service resident, and she was present during his care plan meetings and Minimum Data Set (MDS) admission assessments. She said she had not checked his code status that day and, It could have changed. On [DATE] at 4:29 p.m., an interview was conducted with the Nursing Home Administrator (NHA) regarding the facility's response and investigation related to Resident #1. She said on [DATE] Staff P, CNA answered Resident #1's call light and he expressed feeling shortness of breath (SOB). She said Staff P, CNA told Staff E, LPN who went to check Resident #1's vital signs and determined his oxygen saturation was low at 55% (normal oxygen saturation levels range from 95%-100%). The NHA said Staff E, LPN contacted the provider and received orders to transfer the resident to the hospital. She said Staff E, LPN told the Staffing Coordinator to tell the nurse manager at the time, Staff N, RN, that he was transferring the resident to the hospital. She said Staff N, RN went to Resident #1's room and checked his oxygen saturation twice with the same result, which was 73%. The NHA said Staff N, RN had taken the crash cart to the room with her. She said Staff E, LPN left Resident #1's room to prepare transfer paperwork to include the medication list, face sheet, and the hospital transfer form. The NHA said Staff N, RN started suctioning Resident #1 because he was drooling, while suctioning he had agonal breathing (Insufficient breathing that sounds like snorting, gasping, or labored breathing, and indicates that someone is suffering from a medical emergency. The person can appear to be choking or having an involuntary gasp reflex.), then stopped breathing. She said Staff A, LPN came into the room, checked Resident #1's pulse, did not find a pulse and Staff N, RN instructed Staff A, LPN and Staff B, CNA to transfer Resident #1 to the floor to start chest compressions. The NHA said Staff D, LPN came into the room and took over chest compressions from Staff A, LPN. She said Staff E, LPN came back to the room, while they were waiting for paramedics, and he took over chest compressions for Staff D, LPN. She said they switched to Staff A, LPN, who was doing the chest compressions when paramedics arrived. The NHA said after the paramedics took over, Staff C, RN had gone to Resident #1's room and left to confirm his code status. The NHA said Staff C, RN heard Staff E, LPN, Staff D, LPN, and Staff N, RN say, He's a DNR. The NHA said Staff N, RN took the yellow DNR form to the paramedics who stopped compressions. She said at approximately 3:45 p.m., Staff C, RN informed her CPR had occurred. She said the facility policy is if a resident was unresponsive, staff should assess them and determine their code status. The NHA said if a resident had orders for a DNR, the expectation (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	is not to do chest compressions and ensure they are comfortable. The NHA confirmed she interviewed all the staff involved and they confirmed they were instructed/directed by Staff N, RN to start compressions. She stated, Their thought process was the resident was a full code. She said it had always been the process for the nurse to verify the code status in the electronic health record in the physician orders and dashboard. On [DATE] at 8:31 a.m., a telephone interview was conducted with Staff A, LPN. On [DATE], she said a CNA came and told her Staff N, RN needed assistance. She said the code blue was not called overhead. Staff A, LPN stated when she arrived to Resident #1's room a, Code was in progress, as the crash cart was there. She said she checked Resident #1's pulse. She said Staff N, RN was in the room at that time along with other CNAs. She said Staff N, RN instructed her to put Resident #1 on a back board, then to put him on floor with the assistance of three CNAs. Staff A, LPN said Staff N, RN told her to start chest compressions. She said Staff N, RN was directing everyone during the code. She said she did not confirm Resident #1's code status as Staff N, RN had sent a CNA specifically asking for a nurse, therefore she started chest compressions as directed. Staff A, LPN said Staff D, LPN came in and relieved her, then Staff E, LPN continued chest compressions. She said she did not remember who was doing chest compressions when paramedics arrived and could not recall how many rounds she completed. She said she switched out once. On [DATE] at 10:24 a.m., a follow-up interview was conducted with the NHA, Regional Director of Operations, and Regional Director of Clinical Services. The NHA reviewed the facility's investigation file and read witness statements that revealed Resident #1 was observed earlier in the day on [DATE] wearing oxygen, sounded congested, and was alert/talking. Later in the shift, the resident complained of difficulty breathing and was noted to remove his oxygen, as he expressed it was not helping. Staff Q, CNA and Staff P, CNA both reported notifying Staff E, LPN of the Resident #1's respiratory distress, after which nursing staff responded. Staff N, RN reported responding to the room at approximately 3:10 p.m., after being notified that assistance was needed. Upon her arrival, the resident was drooling and appeared to be in respiratory distress. Staff N, RN directed staff to obtain towels, oxygen equipment, suction, and a non-rebreather mask. The resident was suctioned, placed on a non-rebreather, lowered to the floor, and chest compressions were initiated. Staff N, RN said the resident's code status was not verified prior to initiating compressions and could not recall who checked for a pulse. Paramedics arrived and compressions were discontinued once documentation confirmed the resident had DNR orders. Staff P, CNA corroborated that Staff N, RN was directing care in the room and that multiple nurses were present when the resident was placed on the floor. Staff C, RN reported arriving during the event, observing the crash cart and suction equipment in use, and questioning the resident's code status. She verified on the computer that the resident had a DNR order and heard a paramedic state Resident #1 was a DNR. Further review of the facility's investigation with the NHA, Regional Director of Operations, and Regional Director of Clinical Services revealed the NHA read a timeline that showed chest compressions were initiated at 3:18 p.m. by Staff A, LPN. EMTs arrived at 3:23 p.m. and instructed staff to continue compressions. EMTs took control of the code at 3:30 p.m. At 3:35 p.m., the resident's DNR status was identified. At 3:38 p.m., Staff N, RN provided the DNR documentation to the EMTs, and chest compressions were discontinued. Chest compressions were performed from 3:18 p.m. to 3:38 p.m., totaling approximately 20 minutes. An interview with the Regional Director of Clinical Services revealed before a code blue or initiating CPR, nurses needed to ask for the residents' code status and determine if that information had been checked. The Regional Director of Clinical Services stated, Everybody walking in should ask, was code status checked? She confirmed that two nurses verifying the resident's code status was not the process/protocol before Resident #1's code blue event. On (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Advance Directives - Resident's Right to Make Decision, revealed the following: Purpose . The facility respects the resident's or legal representative's right to make medical treatment decisions and be provided the appropriate information as required under State and Federal Rules and Regulations., A review of the facility policy titled Resident Rights, revealed the following, All residents have rights guaranteed to them under Federal and State laws and regulations. This policy is intended to lay the foundation for the resident rights requirements in long-term care facilities. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input. The facility's immediate actions to remove the Immediate Jeopardy included: - Disciplinary action/suspension was initiated for two nurses. RN was terminated and reported to Board of Nursing. - Nurse files were reviewed and it confirmed CPR certification, license, skills checklists and backgrounds were present for 100% of nurses. - Ad hoc [unplanned/spontaneous] quality assurance performance improvement (QAPI) meetings held on [DATE] and [DATE] to discuss concern and correction plan. [DATE] Ad hoc meeting held to review IJ citations. Ad Hoc meeting on [DATE] at 1:06 p.m. to discuss additional education to evaluate and reinforce education previously provided on code status, abuse, neglect, and exploitation (ANE) reviewed, approved a code blue worksheet, reviewed and approved an abuse posttest to reinforce prior education. [DATE] Ad hoc at 4:31 p.m. to review, revise and approve code blue worksheet. - [DATE] Post ad hoc- took revised code blue worksheet to units and initiated review of the worksheet with staff. Anyone can complete the code blue worksheet. - Education 100% of nurses on advance directives, resident right to make a decision and emergency care (CPR) and ANE by [DATE]. New licensed staff were educated on abuse and code status upon hire. - 100% of resident medical records were reviewed- code status orders were verified. Audit was conducted of residents who expired in facility in past 90 days with no concerns found related to honoring code status. - Mock code drills were initiated on [DATE] at 4:30 p.m. and continued through current date [DATE] on varying shifts and days. - Code status for all new admissions after [DATE] were reviewed and verified. - [DATE] 23 of 23 nurses received reinforcement of prior education to verify and document code status orders. - [DATE] began implementation of the code drill worksheet and feedback received to add a box for full code/ DNR that can be checked. - [DATE] 69 of 104 non-licensed staff received additional education to evaluate and reinforce prior education on code status, who can perform CPR and emergency care, advance directives and ANE and their role during a code blue. - Education initiated on [DATE] and [DATE] is ongoing and staff will complete reinforcement education prior to working next shift. Verification of the facility's removal plan was conducted by the survey team on [DATE]. - Interviews were conducted with twelve out of twenty-three licensed nursing staff and fifteen out of fifty-one licensed CNA's who worked across all shifts. Interviews were conducted with twenty-four staff members who were considered other licensed clinical (dietitian, social work, therapy) and non-clinical staff. The staff members were able to state they had been trained and were knowledgeable about the new policies and procedures initiated by the facility. - A review of in-service documentation revealed 100% of staff currently working had completed education and training related advanced directives policy/procedure, identification and responding to change in condition and order evaluation with competency, verifying code status completed by licensed nursing staff, abuse/neglect/exploitation and participation in code blue drills. - On [DATE] at 2:59 p.m., the facility was asked to conduct a blue code drill. Staff were observed promptly announcing overhead, Code blue, after assessing the resident and verifying their code status. Multiple clinical and non-clinical staff responded without delay. The Director of Nursing (DON) was observed leading the drill. Staff arrived with two crash carts, laptops, and one individual scribed the event on the code blue form/timeline. Multiple staff asked about (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Springs at Boca Ciega Bay		STREET ADDRESS, CITY, STATE, ZIP CODE: 1255 Pasadena Ave S, Suite C South Pasadena, FL 33707	

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and confirmed the resident's code status demonstrating awareness of the protocol/understanding their roles and responsibilities. Based on verification of the facility's immediate jeopardy removal plan the immediate jeopardy was determined to be removed on [DATE] and the non-compliance was reduced to a scope and severity of D.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure nursing staff were competent in identifying residents code status and following physician orders for Do Not Resuscitate (DNR) for one resident (#1) out of six residents sampled.On [DATE], Resident #1 stopped breathing and was without a pulse. The facility staff initiated CPR. Resident #1 had a physician order for Do Not Resuscitate (DNR), dated [DATE]. Cardiac compressions were initiated by staff (Use of hands to push down hard and fast to manually pump blood through the heart. The pressure from cardiac compressions commonly caused physical damage including fractured ribs or sternum, bruising, and internal organ injury). Emergency Medical Services (EMS) were called and paramedics took over compressions. Facility staff informed EMS Resident #1 was a DNR and provided the documentation to the paramedics. Paramedics discontinued compressions. Cardiac compressions were provided to Resident #1 for approximately twenty minutes. The CPR provided for Resident #1 denied him the right to a peaceful death and caused unnecessary physical harm and pain.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #1 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm.Cross reference to F578, F600, and F678.Findings Include: A review of Resident #1's admission record revealed an initial admission to the facility on [DATE], and a re-admission on [DATE] with diagnoses to include myasthenia gravis without (acute) exacerbation, immunodeficiency, unspecified, chronic obstructive pulmonary disease, unspecified, acute pulmonary edema, peripheral vascular disease, unspecified, personal history of transient ischemic attack (tia), cerebral infarction without residual deficits, and adult failure to thrive. A review of Resident #1's physician orders included the following: - Do Not Resuscitate (DNR), with an ordered/created date of [DATE] and an end date of [DATE]. - Do Not Resuscitate (DNR), with an ordered/created date of [DATE] and an end date of [DATE]. - Full Cardiopulmonary Resuscitation (CPR), with an ordered/created date of [DATE] and an end date of [DATE]. Further review of the order had notes with the following, changed to DNR. - Full Cardiopulmonary Resuscitation (CPR), with an ordered/created date of [DATE] and an end date of [DATE]. Further review of the order had notes with the following, Resident is DNR status. The order was created on [DATE] at 3:04 p.m., by Staff A, Licensed Practical Nurse (LPN). The order was discontinued by Staff I, Registered Nurse (RN) on [DATE] at 7:31 a.m. A review of Resident #1's miscellaneous documents revealed the following: - State of Florida DNR order, dated [DATE], with Resident #1 and the physician's signature was scanned into the electronic health record on [DATE] at 3:02 p.m. On [DATE] at 12:03 p.m., an interview was conducted with Staff D, LPN. She said the most recent actual code blue was with Resident #1. She said on [DATE], she overheard a conversation that someone needed a non-rebreather mask. She said she was assisting another resident at the time, and a Certified Nursing Assistant (CNA) told her she was needed on the other side of the facility. She stated it, Made me think something was going on. Staff D, LPN said she went to the long-term care side of the facility and saw a crash cart outside the door of Resident #1's room. She said Staff A, LPN was doing chest compressions. Staff D, LPN said she gave the non-rebreather mask to Staff N, Registered Nurse (RN). She recalled connecting the mask to the oxygen tank, then heard Staff A, LPN say she needed to switch, and Staff D, LPN took over chest compressions. Staff D, LPN said Staff E, LPN relieved her and started doing chest compressions. She said a few minutes later, as Staff E, LPN was doing chest compressions, the paramedics arrived. She said Staff E, LPN continued chest (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	compressions, per the paramedics' advisement, and she left the room. Staff D, LPN said she went to complete the transfer paperwork to include the face sheet, medication list, and transfer to hospital form. She said she noted Resident #1 was not a full code. She stated, When I noted he was a DNR, [Staff E, LPN] and [Staff N, RN] were coming out of the room, paramedics had taken over. Staff D, LPN stated she asked Staff N, RN, Why did we do CPR on a DNR. She said she asked Staff N, RN to talk to the paramedics, while Resident #1's DNR form was printed and provided to the paramedics. She stated, They would not stop until they had the physical DNR in hand. Staff D, LPN said she did not know who initiated compressions and assumed someone checked Resident #1's code status. She stated, The nurse was to check the code status, then to initiate or not to initiate. She said the assigned nurse is expected to check the resident's code status. Staff D, LPN said the code blue sheets are on the crash cart and they are a new process. She said prior to Resident #1's code blue, the facility did not fill out the code blue sheets. She said a code blue is supposed to be announced, prior to and after, over the facility's intercom system. On [DATE] at 12:52 p.m., an interview was conducted with Staff E, LPN. He said the last time there was an actual code blue was about a month ago, and confirmed it was for Resident #1. He said he went into Resident #1's room, observed he was not doing well, and called the provider for orders to transfer him to the hospital. Staff E, LPN confirmed on [DATE] he was Resident #1's assigned nurse. He said he prepared paperwork to include discharge documents, the face sheet, and the medication list. He stated, As I was going to my desk someone was getting the crash cart and going to my patient's room. Staff E, LPN stated the code blue was not called overhead and, It was a big to-do. He said he went to Resident #1's room, observed the resident was on the floor, and staff were doing compressions. He said Staff N, RN was in the room and Staff A, LPN was doing chest compressions. Staff E, LPN confirmed himself, Staff A, LPN, Staff D, LPN did chest compressions, and thought Staff N, RN did as well. He said the first person he observed doing chest compressions was Staff A, LPN, followed by Staff D, LPN, and then himself. He confirmed Resident #1 had physician orders for DNR but did not know at the time chest compressions were done. Staff E, LPN said he did not notice the resident was a DNR because it was not on the face sheet. He stated, Someone must have said something about the resident being a DNR, and could not recall who said that. He said when the paramedics arrived, they took over CPR. He stated, By that time it was known he was a DNR, they [paramedics] could not stop until they had the yellow DNR sheet. He said the resident passed away. He said the process for a resident who is unresponsive has not changed from prior to Resident #1's code blue event. He said the facility staff are, Just doing more drills. Staff E, LPN said he had never seen a code blue log previously or currently. On [DATE] at 1:23 p.m., an interview was conducted with Staff C, RN. She stated on [DATE] she was in her office and heard a commotion, then responded to Resident #1's room. She said when she arrived, Things were taking place. She said she saw a crash cart, staff present were suctioning Resident #1, and he was lowered to the ground. She stated her part in the code blue was minimal, Nothing at all. Staff C, RN stated the commotion she heard was staff saying, We need help, call 911. She said she observed Staff N, RN suctioning Resident #1, and was leading the code. Staff C, RN said Staff B, CNA were assisting and moving items out of the way, and Staff A, LPN was following guidance from Staff N, RN. She said Staff A, LPN started chest compressions, after being instructed by Staff N, RN. She said she did not hear a code blue was called. She said in response to a resident's change in condition she would use her nursing judgment, which is to check their code status, call code blue over the intercom, and grab the crash cart if it was appropriate. She confirmed Resident #1 was a DNR. Staff C, RN stated she knew his code status because Resident #1 was her, Customer service resident, and she was present during his care plan meetings and (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Minimum Data Set (MDS) admission assessments. She said she had not checked his code status that day and, It could have changed. She did not think there were code blue sheets currently and they were not part of the process prior to Resident #1's code blue event. Staff C, RN stated, No, I have not seen that here as far as code blue sheets. On [DATE] at 2:05 p.m., an interview was conducted with the Central Supply/Staffing Coordinator. The Coordinator said on [DATE], she was walking down the hall to go back to her office. She said Staff E, LPN, was coming out of Resident #1's room and told her to get another nurse. The Central Supply/Staffing Coordinator said she told Staff N, RN she was needed in Resident #1's room. She said Staff E, LPN was getting ready to send Resident #1 to the hospital and thought he was on the telephone with emergency services. The Central Supply/Staffing Coordinator said Staff E, LPN did not tell her why he needed a nurse. She said approximately five to ten minutes later, she walked back down the hallway and observed multiple people in Resident #1's room. She said she did not hear code blue being called. She said she assisted with getting Resident #1 off the floor to the bed. She said she recalled Staff A, LPN and Staff N, RN being in the room, as well as paramedics who were getting ready to leave. She said she had never participated in an actual code blue, but her role would be to get the crash cart and/or call emergency services. The Central Supply/Staffing Coordinator initially stated, I can verify code status in the book, but not in the computer. She said to her understanding there was a code status book and code status could also be found in the Kardex. She said she could not confirm if her role was to check the code status book, but she would find out. On [DATE] at 3:01 p.m., an interview was conducted with Staff I, RN. She confirmed she was not present during the event on [DATE] but was told a nurse started resuscitation. She stated the code blue response process, Hasn't changed, the regulation never changes. Staff I, RN said the facility completed a timeline of what happened during a code. She said the timeline had always been protocol at the facility. She said in a code blue, her role was the person in charge. Staff I, RN stated, The first person is to check the computer for status. She said she would first check the code status in the computer and would not touch a resident without knowing that information. She said the code blue sheets/timeline should be on the crash cart and confirmed they were not at the time of interview. A follow-up interview and observation was conducted at 3:18 p.m., Staff I, RN said the facility does not keep a book of the residents' code status as they are found in the electronic health record. The crash cart was observed, and the code blue sheets/timelines were not present. Staff I, RN verified the sheets were not on the crash cart and could not provide an explanation as to where they were. On [DATE] at 3:12 p.m., an interview was conducted with Staff J, CNA. She said her role in a code blue is to come in with other staff and attend to anything going on. She stated, I basically don't know if I can do CPR here, but I am CPR certified. She stated, I guess I can do it, why else would they ask for it. On [DATE] at 3:16 p.m., an interview was conducted with Staff K, CNA. She said she was not working on [DATE]. She stated, Code blue was called on one of our residents, and confirmed she had been Resident #1's assigned CNA. Staff K, CNA said the facility had a book that listed the residents' code status and the Kardex also had code status information. On [DATE] at 3:21 p.m., an interview was conducted with Staff L, LPN. She said she was not present for the code blue on [DATE] and did not hear anything about it. Staff L, LPN said the facility staff do not complete a code blue sheet or timeline. She stated, Not that I'm aware of. On [DATE] at 3:26 p.m., an interview was conducted with Staff M, CNA. She said during a code blue, she may check the resident for a pulse. Staff M, CNA said if a nurse was not present, she could start chest compressions. She confirmed she could do CPR and every three months she completed a CPR refresher. On [DATE] at 4:29 p.m., an interview was conducted with the Nursing Home Administrator (NHA) regarding the facility's response and (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	investigation related to Resident #1. She said on [DATE] Staff P, CNA answered Resident #1's call light and he expressed feeling shortness of breath (SOB). She said Staff P, CNA told Staff E, LPN who went to check Resident #1's vital signs and determined his oxygen saturation was low. The NHA said Staff E, LPN contacted the provider and received orders to transfer the resident to the hospital. She said Staff N, RN, nurse manager at that time, was informed by the Staffing Coordinator she was needed in Resident #1's room. Staff N, RN went and checked Resident #1's oxygen saturation twice with the same result, which was 73%. The NHA said Staff N, RN had taken the crash cart to the room with her. She said Staff E, LPN left Resident #1's room to prepare transfer paperwork. The NHA said Staff N, RN started suctioning Resident #1 because he was drooling, while suctioning he had agonal breathing (Insufficient breathing that sounds like snorting, gasping, or labored breathing, and indicates that someone is suffering from a medical emergency. The person can appear to be choking or having an involuntary gasp reflex.), then stopped breathing. She said Staff A, LPN came into the room, checked Resident #1's pulse, did not find a pulse. Staff N, RN instructed Staff A, LPN and Staff B, CNA to transfer Resident #1 to the floor to start chest compressions. The NHA said Staff D, LPN came into the room and took over chest compressions from Staff A, LPN. She said Staff E, LPN came back to the room, while they were waiting for paramedics, and he took over chest compressions for Staff D, LPN. She said they switched to Staff A, LPN, who was doing the chest compressions when paramedics arrived. The NHA said after the paramedics took over, Staff C, RN went to Resident #1's room and left to confirm his code status. The NHA said Staff C, RN heard Staff E, LPN, Staff D, LPN, and Staff N, RN say, He's a DNR. She said Staff N, RN took the DNR paper to the paramedics who stopped compressions. She said at approximately 3:45 p.m., Staff C, RN informed her CPR had occurred. She said the facility policy is if a resident was unresponsive, staff should assess them and determine their code status. The NHA said if a resident had orders for a DNR, the expectation is not to do chest compressions and ensure they are comfortable. The NHA confirmed she interviewed all the staff involved and they confirmed they were instructed/directed by Staff N, RN to start compressions. She stated, Their thought process was the resident was a full code. She said it had always been the process for the nurse to verify the code status in the electronic health record in the physician orders and dashboard. The NHA confirmed CNAs are not allowed to do CPR. She said there is a paper attached to the crash cart where staff take notes, she said that it had always been part of the code blue process. She confirmed the code blue form/timeline was not completed for Resident #1. The NHA said there had been no change to the code blue response process after the incident with Resident #1. On [DATE] at 8:31 a.m., a telephone interview was conducted with Staff A, LPN. On [DATE], she said a CNA came and told her Staff N, RN needed assistance. She said the code blue was not called overhead. Staff A, LPN stated when she arrived to Resident #1's room a, Code was in progress, as the crash cart was there. She said she checked Resident #1's pulse. She said Staff N, RN was in the room at that time along with other CNAs, who she could not recall their names. She said Staff N, RN instructed her to put Resident #1 on a back board, then to put him on floor with the assistance of three CNAs. Staff A, LPN said Staff N, RN told her to start chest compressions. She said Staff N, RN was directing everyone during the code. She said she did not confirm Resident #1's code status as Staff N, RN had sent a CNA specifically asking for a nurse, therefore she started chest compressions as directed. Staff A, LPN said Staff D, LPN came in and relieved her, then Staff E, LPN continued chest compressions. She said she did not remember who was doing chest compressions when paramedics arrived and could not recall how many rounds she completed. She said she switched out once. She stated, Usually if a code is called, I grab the computer and look at the face sheet. Staff A, LPN said the facility does not have a code status (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	book, with physical copies of the yellow DNR form, at the nurse's station. She confirmed there is a clipboard with blank pages of paper on the crash cart where notes could be taken. She said typically the first staff member who arrived completed the notes, whoever is leading the code. On [DATE] at 9:42 a.m., a follow-up interview was conducted with Staff D, LPN. She said the facility does not keep a code status book at the nurse's station. She stated, Everything is on the computer. On [DATE] at 10:24 a.m., a follow-up interview was conducted with the NHA, Regional Director of Operations, and Regional Director of Clinical Services. The NHA reviewed the facility's investigation file and read witness statements that revealed Resident #1 was observed earlier in the day on [DATE] wearing oxygen, sounded congested, and was alert/talking. Later in the shift, the resident complained of difficulty breathing and was noted to remove his oxygen, as he expressed it was not helping. Staff Q, CNA and Staff P, CNA both reported notifying Staff E, LPN of the Resident #1's respiratory distress, after which nursing staff responded. Staff N, RN reported responding to the room at approximately 3:10 p.m., after being notified that assistance was needed. Upon her arrival, the resident was drooling and appeared to be in respiratory distress. Staff N, RN directed staff to obtain towels, oxygen equipment, suction, and a non-rebreather mask. The resident was suctioned, placed on a non-rebreather, lowered to the floor, and chest compressions were initiated. Staff N, RN said the resident's code status was not verified prior to initiating compressions and could not recall who checked for a pulse. Paramedics arrived and compressions were discontinued once documentation confirmed the resident had DNR orders. Staff P, CNA corroborated that Staff N, RN was directing care in the room and that multiple nurses were present when the resident was placed on the floor. Staff R, Medical Records, reported hearing staff say, call 911, at approximately 3:11 p.m. she called, and observed paramedics arrived shortly after. Staff C, RN reported arriving during the event, observing the crash cart and suction equipment in use, and questioning the resident's code status. She verified on the computer that the resident had a DNR order, heard a paramedic state Resident #1 was a DNR, and afterward informed the NHA of the incident as she was not aware there was a code. Further review of the facility's investigation with the NHA, Regional Director of Operations, and Regional Director of Clinical Services revealed the NHA read a timeline that showed chest compressions were initiated at 3:18 p.m. by Staff A, LPN. EMTs arrived at 3:23 p.m. and instructed staff to continue compressions while they prepared equipment and gathered information. EMTs took control of the code at 3:30 p.m. At 3:35 p.m., the resident's DNR status was identified. At 3:38 p.m., Staff N, RN provided the DNR documentation to the EMTs, and chest compressions were discontinued. Chest compressions were performed from 3:18 p.m. to 3:38 p.m., totaling approximately 20 minutes. An interview with the Regional Director of Clinical Services revealed before a code blue or initiating CPR, nurses needed to ask for the residents' code status and determine if that information had been checked. The Regional Director of Clinical Services stated, Everybody walking in should ask, was code status checked? She confirmed that two nurses verifying the resident's code status was not the process/protocol before Resident #1's code blue event. The Regional Director of Clinical Services and the Regional Director of Operations said the leader or whoever is designated should be taking notes on a clipboard found on the crash cart. The NHA stated, Probably not, when asked about notes being documented on the code blue event for Resident #1. She said she was not sure if staff were aware of the expectation to take notes during a code blue, but now it was being emphasized during education and the mock drills. On [DATE] at 11:51 a.m., a telephone interview was conducted with Staff F, Medical Doctor (MD). She confirmed Resident #1 was re-admitted to the facility on [DATE], but she was not the admitting provider or on call. She said a few days after the re-admission, she was called by Staff G, NP who was getting ready to transfer him to the (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital, then Resident #1 passed away. She said Staff G, NP told her she was on the phone with Staff E, LPN who said, [Resident #1] got bad. She stated, He did not want anything aggressive, no feeding tube done. She stated, He did not want anything artificial, did not want anything invasive. She said he had myasthenia gravis and he started deteriorating, eating less, and had swallowing issues. She said she sent him to hospital on [DATE], to be seen by a neurologist and to determine if the symptoms he was having was related to myasthenia gravis, or something else. Staff F, MD said she thought he was diagnosed with pneumonia while at the hospital as he was sent back with treatment. She stated she thought he had DNR orders, 99% sure I can tell you. She said if Resident #1's code status had not changed during the admission at the hospital, and his wishes were for DNR, the facility should not have resuscitated him. On [DATE] at 12:13 p.m., a telephone interview was conducted with Staff G, Nurse Practitioner (NP). She said when Resident #1 was re-admitted on [DATE] the nurse called her to let her know the resident was back and they verified admission orders. Staff G, NP said she did not discuss advanced directives but told the nurse to continue whatever orders the resident had from the hospital. She stated, After the hospitalization, whatever wishes he wanted in the hospital it was for the nursing home to follow. She stated she could not remember his code status. She said she recalled a second interaction, when the nurse called and said Resident #1 was in respiratory distress and was doing all possible measures at bedside. She said she told the nurse to call 911 and transfer him to the hospital based on symptoms he was having. Staff G, NP said she did not recall a follow up call after the initial communication with the nurse about sending Resident #1 to the hospital. She stated, Not sure they mentioned chest compressions during call. Staff G, NP said by the standards of care if a resident had signed orders for DNR, then chest compressions should not be started. On [DATE] at 2:31 p.m., an interview was conducted with Staff B, Certified Nursing Assistant (CNA). She said on [DATE] at approximately 3:00 p.m. there was a call light on for Resident #1's room. She said she helped Staff A, LPN move Resident #1 to the floor as instructed by Staff N, RN. Staff B, CNA said it was only her and Staff A, LPN who moved the resident. She said she informed Staff N, RN that CNAs were not allowed to do CPR and left the room. When she left the room, she said she informed one of the Minimum Data Set (MDS) nurses to call 911. A review of the position description for licensed practical nurses revealed the following: .Essential Functions 1. Works under direct supervision using the Nurse Practice Act, Policies and Procedures and nursing judgement. 4. Implements the resident plan of care and evaluates the resident response. 12. Initiates the emergency support measures (i.e. CPR, protects patients/residents from injury). General Patient/Resident Care . 8. Emergency situations are recognized and appropriate action is instituted. A review of the position description for registered nurses revealed the following: .Essential Functions 1. Works using the guidelines established from the Nurse Practice Act, COMPANY Standards, Policies and Procedures and nursing judgement. 4. Implements the patient/resident plan of care and evaluates the patient/resident response. 13. Initiates emergency support measures (i.e. CPR, protects patients/residents from injury). A review of the position description for the unit supervisor-LPN revealed the following: .Knowledge/Skills/Abilities . 3. Knowledge of medical principles (symptoms, treatment alternatives, drug properties and interactions, and preventive health care). 4. Knowledge of applicable federal, state, and local regulations. A review of the facility policy titled Nursing Policies- Emergency Care (CPR), revealed the following: Policy . The facility will identify each resident's choice for treatment and care, help the resident to develop advance directives, as desired, and implement appropriate instructions for care that reflect those choices, all in accordance with the facility's ethics decision making policies and procedures, and Florida State law. Prior to the arrival of emergency medical services (EMS), the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105537	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Boca Ciega Bay	1255 Pasadena Ave S, Suite C South Pasadena, FL 33707

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility will provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest or respiratory arrest in accordance with the resident's advance directive or Do-Not-Resuscitate (DNR) order., Procedure . 2. The resident or legal representative will be made aware that the resident has the right not to have CPR performed in the event of a cardiac emergency. Should the resident or legal representative request to not have CPR performed in the event of a cardiac emergency, the facility will provide a yellow DO NOT RESUSCITATE form and explain the terms to the resident or legal representative. 3. Once the resident or resident's legal representative and physician, autonomous advanced practice registered nurse or physician assistant have signed the Yellow DNR form, it will serve as the physician order concerning CPR for the resident, . 7. Should a resident experience cardiac emergency, staff will refer to the presence of the yellow form signed by the resident and physician, and/or the physicians order to determine if CPR should be performed. A review of the facility policy titled Admission/Social Services - Advance Directives, revealed the following: .Procedure. 5. Should the resident or legal representative request to not have CPR performed in the event of a cardiac emergency, the facility will provide a yellow DO NOT RESUSCITATE form and explain the terms to the resident or legal representative. Once the resident or resident's legal representative and physician, autonomous advanced practice registered nurse or physician assistant have signed the Yellow DNR form, it will serve as the physician order concerning CPR for the resident. A review of the facility policy titled Admission/Social Services - Advance Directives - Resident's Right to Make Decision, revealed the following: Purpose . The facility respects the resident's or legal representative's right to make medical treatment decisions and be provided the appropriate information as required under State and Federal Rules and Regulations., A review of the facility policy titled Nursing - Admitting/Readmitting a Resident, revealed the following: Procedure The admission / readmission Procedure is initiated upon the resident's arrival to the facility. The nursing department, at a minimum will complete the following: . 2. Verify that transfer documentation is received and includes: . Codes status/Advance Directives . 5. Obtain additional physician orders as indicated and verify the following: . Code status/Advance Directives . 6. Accurately and completely transcribe verified physician orders onto the POS [point of service], MAR [medication administration record], TAR [treatment administration record], ADL [activities of daily living] sheets and/or other necessary locations and note when completed. A review of the facility policy titled Resident Rights, revealed the following: All residents have rights guaranteed to them under Federal and State laws and regulations. This policy is intended to lay the foundation for the resident rights requirements in long-term care facilities. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input. The facility's immediate actions to remove the Immediate Jeopardy included: - Disciplinary action/suspension was initiated for two nurses. RN was terminated and reported to Board of Nursing. - Nurse files were reviewed and it confirmed CPR certification, license, skills checklists and backgrounds were present for 100% of nurses. - Ad hoc [unplanned/spontaneous] quality assurance performance improvement (QAPI) meetings held on [DATE] and [DATE] to discuss concern and correction plan. [DATE] Ad hoc meeting held to review IJ citations. Ad Hoc meeting on [DATE] at 1:06 p.m. to discuss additional education to evaluate and reinforce education previously provided on code status, ANE reviewed, approved a code blue worksheet, reviewed and approved an abuse posttest to reinforce prior education. [DATE] Ad hoc at 4:31 p.m. to review, revise and approve code blue worksheet. - [DATE] Post ad hoc- took revised code blue worksheet to units and initiated review of the worksheet with staff. Anyone can complete the code blue worksheet. - Education 100% of nurses on advance directives, resident right to make a decision and emergency care (CPR) and ANE by [DATE]. New (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Springs at Boca Ciega Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 Pasadena Ave S, Suite C South Pasadena, FL 33707	

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	licensed staff were educated on abuse and code status upon hire. - 100% of resident medical records were reviewed- code status orders were verified. Audit was conducted of residents who expired in facility in past 90 days with no concerns found related to honoring code status. - Mock code drills were initiated on [DATE] at 4:30 p.m. and continued through current date [DATE] on varying shifts and days. - Code status for all new admissions after [DATE] were reviewed and verified. - [DATE] 23 of 23 nurses received reinforcement of prior education to verify and document code status orders. - [DATE] began implementation of the code drill worksheet and feedback received to add a box for full code/ DNR that can be checked. - [DATE] 69 of 104 non-licensed staff received additional education to evaluate and reinforce prior education on code status, who can perform CPR and emergency care, advance directives and abuse, neglect, and exploitation (ANE) and their role during a code blue. - Education initiated on [DATE] and [DATE] is ongoing and staff will complete reinforcement education prior to working next shift. Verification of the facility's removal plan was conducted by the survey team on [DATE]. - Interviews were conducted with twelve out of twenty-three licensed nursing staff and fifteen out of fifty-one licensed CNA's who worked across all shifts. Interviews were conducted with twenty-four staff members who were considered other licensed clinical (dietitian, social work, therapy) and non-clinical staff. The staff members were able to state they had been trained and were knowledgeable about the new policies and procedures initiated by the facility. - A review of in-service documentation revealed 100% of staff currently working had completed education and training related advanced directives policy/procedure, identification and respondin

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record reviews, policy reviews, Quality Assurance Performance Improvement (QAPI) documentation, and interviews the facility failed to ensure staff were educated and had the tools to respond to a resident's change in condition related to knowing if the Certified Nursing Assistant's (CNA) were allowed to perform cardiopulmonary resuscitation (CPR) and if code blue forms were utilized during a code.Findings included:Review of Resident #1's record showed signed Do Not Resuscitation Order (DNRO) on [DATE]. Review of Resident #1's hospital records (found in the facility's uploaded miscellaneous documents for the resident) showed the acute care facility, had noted on 12/24 and [DATE] the resident's code status was Do Not Resuscitate (DNR). The uploaded documents did not reveal the order had been rescinded. Review of Resident #1's physician orders showed a DNR order was initiated on [DATE]. Review of Resident #1's progress notes showed the resident suffered a change in condition while at the facility on [DATE]. While Staff N, Registered Nurse (RN), was assessing the resident, the resident stopped breathing and had no pulse as reported by Staff A, Licensed Practical Nurse (LPN). Staff N, RN directed Staff A, LPN and Staff B, Certified Nursing Assistant (CNA) to place resident on the floor and begin chest compressions. Staff B informed Staff N that CNA's were not allowed to perform CPR at the facility. Staff D (LPN) and Staff E (LPN) continued CPR until Emergency Medical Services (EMS) arrived and took over. Interviews on 1/20, 1/21, and [DATE] with staff, including the Nursing Home Administrator (NHA), the Regional Nurse Consultant, Regional Director of Operations, that Staff A, Staff B, Staff D, and Staff E did not verify Resident #41's code status prior to performing CPR on Resident #1 whose wishes were not to resuscitated. During an interview on [DATE] at 4:29 p.m. the NHA stated recalling the event with Resident #1. The NHA said if staff discovered a resident to be unresponsive, the staff would assess the resident and determine code status. If a resident has a DNR then staff should not start chest compressions. The NHA stated CNAs are not allowed to perform CPR. The NHA stated if CPR is started, the code should be documented. The facility has attached blank paper to the crash cart for staff to take notes of vital signs, code status, who was involved, was 911 called and then following the code was the physician and family notified. The NHA confirmed the process was not new and had been in place at the time of the incident. The NHA stated staff had not used the blank paper to note the actions taken during Resident #1s event. The NHA stated the code status is verified by the physician order (electronic). The NHA said on [DATE] staff education occurred regarding abuse and neglect, mock (code) drills were started and continued for 7 days on each shift. The NHA stated all nurses have participated in these drills. The NHA stated no change in the process was needed based on the results of the mock drills. An interview was conducted on [DATE] at 12:03 p.m. with Staff D, LPN. Staff D reported participating in the chest compressions of Resident #1. The staff member reported the code sheets are on the crash cart and the process was not new. Staff D stated CNAs are not allowed to perform CPR, they can take direction from the nurse and grab the computer. An interview was conducted on [DATE] at 12:52 p.m. with Staff E, LPN. Staff E confirmed performing chest compressions on Resident #1. The staff member reported Resident #1s code was not paged overhead, it was a big to do, the process hasn't changed just doing more drills and had never see a code blue log (form) until now. An interview was conducted on [DATE] at 2:45 p.m. with Staff H, LPN. The staff member reported thinking the facility used code sheets (forms), thought they were on the crash cart, Aren't they standard?. An interview was conducted on [DATE] at 3:01 p.m. with Staff I, Registered Nurse (RN). Staff I reported being educated on code blues and does the mock codes on the weekends. The staff member stated the process hadn't changed, the regulation never changes, (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility does a timeline of what happens during a code, and the timeline has always been the protocol. The staff member stated the code sheets/timeline should be on the crash cart but wasn't. An interview was conducted on [DATE] at 3:12 p.m. with Staff J, CNA. The CNA reported not knowing if CNAs allowed to do CPR. If the CNA is CPR certified, then guess they could do it why else would they [the facility] have asked for it [the CPR certification]. An interview was conducted on [DATE] at 3:16 p.m. with Staff K, CNA. The staff member reported being educated on a code blue, and the CNA role is to call 911, and anything else the nurse requests. Staff K stated the facility has a book listing resident's code statuses at the desk. An interview was conducted on [DATE] at 3:21 p.m. with Staff L, LPN. The staff member reported the facility doesn't do a code timeline, not that I'm aware of. A review of the policy - Quality Management, undated, revealed This facility will create a caring and nutrient environment, focused on professionalism and excellence in service delivery. The facility strives to be the provider of choice as well as the employer of choice in our community. The facilities mission statement is to provide quality focused care, one resident at a time. Through quality assurance and performance improvement (QAPI), the facility will take a proactive approach to continually improving care and services to our residents. The facility will involve residents, staff, and other partners to realize our vision of being both the provider and the employer of choice in this community. To do this, all employees will participate in ongoing QAPI efforts to support our mission of providing quality focused care, one resident at a time. The guiding principles included: The facility will use QAPI to make decisions and improve the day-to-day operationsQAPI will include all employees, every department, and all services providedQAPI focuses on systems and processes, rather than individuals.The facility will support performance improvement by encouraging our staff to support each other as well as to be accountable for their own professional performance and practice.The facility we'll make decisions based on data, which will include the input and experiences of caregivers, residents, health care partners, families, and other stakeholders.The desired outcome of QAPI in the facility is the improved quality of care in the enhanced quality of life for our residents. The administrator is responsible for the quality assessment and assurance committee for the facility. The facility will have an internal quality assurance and performance improvement program designed to provide a comprehensive approach to high ensuring high quality care and services. The QA&A Committee referred to as the QAPI committee, we'll meet at least monthly and we'll utilize the five elements of QAPI which are: Design and ScopeGovernance and LeadershipFeedback, Data Systems, and MonitoringPerformance Improvement Projects (PIPs)Systemic Analysis and Systemic Action The composition and duties of the QAPI committee included: 2. The Committee Will identify opportunities for improvement as well as recommend, implement, monitor, and evaluate changes. The committee will address all systems of care and management practices, immune for safety and high quality while emphasizing an autonomy and choice in daily life for residents. It utilizes the best available evidence to define and measure goals.3. The Committee will obtain data from multiple sources, including performance indicators which are benchmarked, and will incorporate input from staff, residents, families, and others as appropriate.4. The Committee will charter performance improvement projects (PIPs) to provide concentrated efforts to address a particular problem areas identified in one part of a facility or facility wide. The facility conducts PIPs to examine and improve care or services by gathering information systematically to clarify issues and intervening for improvement.6. Once the root cause has been established, changes or corrective actions tightly linked to the root cause will be implemented. These changes are corrective measures should offer long term solutions to the problem, and must be achievable, objective, and measurable.