STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105610	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Aventura	21251 E Dixie Highway North Miami Beach, FL 33180

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy 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** 45019 Based on record review and interview, the facility failed to ensure Residents are free from neglect by not honoring the advance directives for one (Resident #1) out of three residents sampled with a Do Not Resuscitate (DNR) order as evidenced by staff initiated Cardiopulmonary Resuscitation (CPR) on Resident #1. This deficient practice had the likelihood for Resident #1 to have suffered from unnecessary pain and suffering during this procedure and was not afforded the right to die with dignity due to the facility's staff failure to honor the resident's advanced directive by initiating CPR that resulted in medical neglect. The facility neglected to follow the procedure to verify code status prior to initiating CPR. This situation resulted in immediate jeopardy. There were twenty-three residents with DNR orders out of the one hundred and seventy residents residing in the facility at the time of the survey. The findings Included: Record review revealed, on [DATE], Registered Nurse (RN) (Staff A) was called to the resident's room by Certified Nursing Assistant (CNAS) (Staff F) and found Resident #1 unresponsive with no vital signs. Resident #1 had a Do Not Resuscitate (DNR) order. RN, Staff A, failed to check the resident's code status and initiated CPR. Review of the facility's policy and procedure titled, Advance Directives and Code Status revision date [DATE] revealed: The Center will perform Cardiopulmonary Resuscitation (CPR) on residents that do not have a physician order for Do Not Resuscitate (DNR). However, the Center will support the right of every Resident to make decisions, including the right to accept or decline CPR in the event of cardiac arrest. Procedure: 7. If a resident is found unresponsive, the Electronic Records (HER/PCC) must be accessed to determine the code status order by a licensed nurse, for any resident without a physician's order for DNR, or without documented wishes to withhold CPR, EMS (911) is called, the attending physician notified, and emergency basic life support (CPR) is initiated by a licensed nurse. Procedure:10. CPR is only initiated by a licensed nurse after the PCC order is verified by a licensed nurse and a physical assessment by a licensed nurse indicates the lack of vital signs. CPR is not initiated if a resident/guest has a pulse and/or respirations. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation revision date ,d+[DATE] revealed: Neglect as defined in statue 483.5 is the failure of the Center, its team members or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This occurs when the Center is aware or should have been aware of goods or services that the resident(s) required but the center failed to provide them resulting in or may result in physical harm, pain, mental anguish or emotional distress. Record review of the facility's abuse/neglect log revealed the incident was reported to the state agency as neglect. An AHCA (Agency for Healthcare Administration) Federal Immediate and Five-Day Reports were submitted by the facility timely. Review of the Florida Do Not Resuscitate (DNR) Form revealed the DNR form was signed by Resident #1's son and the physician on [DATE]. Review of the medical records for Resident #1 revealed the resident was admitted to the facility on [DATE], readmitted on [DATE]. Clinical diagnoses included but not limited to: Chronic Respiratory Failure. Resident #1 was discharged on [DATE] to a local hospital. Review of the Physician's Orders Sheet for [DATE] revealed Resident #1 had orders that included but not limited to: Code Status: DNR ([DATE]), Advance Directive DNR [DATE]. Record review of Resident #1 's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns Brief Interview for Mental Status Score of 12 out of 15, indicating the resident was moderately impaired cognitively. Section J for Health Conditions section documented in prognosis- the resident does not have a condition or chronic disease that may result in a life expectancy of less than 6 months. Section O for Special treatments and Procedures documented the resident was receiving oxygen therapy, suctioning and tracheostomy care. Record review of Resident #1 's Care Plans Reference Date [DATE] documented: Resident has the following Advanced Directives on record: Living Will; Health Care Surrogate; Durable Power of Attorney for health care decisions; DNR and order. Resident's Advanced Directives are in effect, and her wishes and directions will be carried out in accordance with her advanced directives on an ongoing basis. Interventions include-Advise resident and/or appointed health care representative to provide copies to the center of any updated Advance Directives. Appoint a health care representative if resident is incapacitated. Discuss Advanced Directives with the resident and/or appointed health care representative. Identify resident's chart with DNR documentation Notify physician (MD) of resident's wishes regarding life-prolonging procedures. Notify MD to assess the capacity of the resident and certify capacity or incapacity. The appointed health care representative will make all health care decisions if the resident is incapacitated. Resident/resident representative has chosen Do Not Resuscitate (DNR). If the resident's heart stops, or if they stop breathing, CPR will not be initiated in honor with their DNR wishes. An advanced directive can be revoked or changed if the resident/resident representative changes their mind about the medical care they want delivered. Interventions Include-Request the resident/representative provide the facility with any Advanced Directive documents. Verify presence of physician's order for DNR. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing progress notes created by a Registered Nurse (RN) for Resident #1 dated [DATE], timestamped 04:00 documented: Alerted to room by CNA. Upon arrival at the resident's room observed the resident lying still not responding to name call, no movements noted. Unable to palpate any pulse, unable to obtain readable vitals. Code alert called, 911 activated and CPR initiated. 911 responded and took over CPR. The resident was transported to a local hospital. Resident's son notified of resident being transferred to the hospital, CPR in progress. Son stated it's ok with me whatever we do for his mom. The resident's son ended the call by thanking the caller for all that was done for his mother. Advanced Nurse Practitioner was notified of the resident's transfer to the hospital. Interview on [DATE] at 6:55 AM with 11:,d+[DATE]:00 AM Licensed Practical Nurse (LPN), stated: I work on the second floor, on [DATE], after 3:00 AM in the morning a CNA (Staff F) told me there is a code blue on the 1st floor in room [room number] window, I went to the 1st floor with her, I went in the room, the assigned [Staff A, RN] was in the room with the crash cart and she had the Ambu Bag in her hand, I went to get the vital sign machine, other staff were assisting to place the hard board underneath the resident in bed. [Staff B, RN] then came into the room while on the phone and stated 911 wants to hear the counting of the compressions on the resident, [Staff A, RN] and [Staff C, LPN] started the CPR. I placed the blood pressure cuff on the resident, and I assisted with the CPR after a few minutes. A police officer showed up and helped with CPR, Emergency Medical Services (EMS) came shortly after and took over the CPR, I left the room once EMS entered the room. Recently I received trainings on CPR drills-the steps to perform for a blue-all code staff report, nurse check on status of resident, determine what care to provide, Do Not Resuscitate (DNR)-we do not initiate CPR, provide 02 (oxygen) and keep the resident comfortable, notify the family and MD. Full code resident-we call 911, initiate CPR until 911 arrives and then they take over. Interview on [DATE] at 7:00 AM LPN (Staff C) from the 11:,d+[DATE]:00 AM shift stated : On [DATE] I worked on the second floor, between 3:,d+[DATE]:00 AM the CNA (Staff F) came to the second floor and told me there was a code blue on the 1st floor, I called [Staff D, LPN] and we went to the first floor to the room where the resident was, I saw [Staff B,RN] on the phone, [Staff F, CNA] grabbed the CPR hard board, we entered the room, I saw [Staff A, RN) with the Ambu Bag in her hand and the crash cart was in the room, I asked [Staff A,RN] if the resident was full code,[Staff A,RN] stated yes, I said how come no one is starting CPR, and asked [Staff D, LPN] to grab the vital sign machine, I then assisted [Staff F, CNA]with placing the CPR hardboard underneath the resident in bed, [Staff A, RN] placed the Ambu Bag on the resident and then I started compressions. [Staff B, RN] came into the room on the phone and stated 911 cannot hear us counting the compressions, we started counting louder so 911 could hear, the police officer arrived and took over compressions, he then stepped outside and someone else took over compressions, I do not remember which nurse it was that took over the compressions from the police officer, EMS arrived and took over, I then exited the room. [Staff B, RN] was getting the resident's paperwork ready for discharge and myself, and [Staff D, LPN] went back to our floor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 7:39 AM Staff F, CNA 11:00 -700 AM shift stated: On [DATE] around 4:00 AM [Staff E, CNA] called me and wanted me to look at her resident [Resident #1], I went to the resident's room, the resident was pale, I left [Staff E] in the room and went to look for the nurse, I saw [Staff A, RN] and asked [Staff A, RN] if the resident is a full code, [Staff A, RN] stated yes, I went to get the crash cart and I called the other nurse on the floor [Staff B, RN]. [Staff B, RN] went to the nursing station and called to the second floor, then [Staff B, RN] told me to go upstairs to get the other nurses from the second floor. I got [Staff D, LPN], [Staff C, LPN] and we all came downstairs to [Resident's #1] room. I grabbed the CPR hard board on the way to [Resident# 1's] room, I placed the CPR hard board underneath the resident, [Staff A, RN] placed the Ambu Bag on the trach, the nurses in the room started CPR, the police arrived and helped with CPR, After the police arrived, I left the room to go take care of my residents. Interview on [DATE] at 8:32 AM CNA (Staff G) via telephone stated: On [DATE] stated via translator on the telephone on [DATE] around 3:00 AM I did care on [Resident #1], and she was her normal self. Staff G revealed she checked on the resident later and she did not look good, her breathing was low. I called the other CNA [Staff F]and then we went to get the Registered Nurses [Staff A and Staff B]. Staff G revealed she recently received training in CPR and DNR. She stated: When a code blue is called, we report to the nurse and wait for instructions on what we need to do, I do not perform CPR on the residents, only the nurse. On [DATE] at 11:00 AM,[DATE] at 8:40 AM and 9:20 AM attempts were made to conduct a telephone interview with Staff A, RN; messages for a return call with the surveyor's name and phone number for a return call and no return call received. On [DATE] attempts were made to reach Staff B, RN via telephone at 11:05 AM, [DATE], 8:45 AM and 9:25 AM to conduct an interview with Staff B, RN, messages with the surveyor's name and phone number for a return call and no response received. Interview on [DATE] at 10:00 AM, the Director of Nursing (DON) stated: The incident that occurred on [DATE] was reported to me around 5:00 AM, [Staff A,RN] stated that she performed CPR on a resident with a DNR, I asked her if they told EMS, I instructed [Staff A,RN] to call the hospital and let the staff know the resident was a DNR and to let the family know that the resident went to the hospital and was given CPR. I asked [Staff A' RN] did she check the resident's code status, [Staff A, RN] stated she was in shock and panicked and she did not check the resident's code status. I asked [Staff A, RN] what she was supposed to do in the specific incident, [Staff A, RN] stated first she was supposed to check the resident's code status and go from there. [Staff A, RN] was removed from the schedule the same day ([DATE]) pending the outcome of the investigation and has not been reinstated on the schedule as of today. We have not been able to get a hold of [Staff A, RN], the last call to [Staff A, RN) was placed on [DATE] and we have sent email correspondence, text message and mail to [Staff A, RN], no response has been received. [Staff B, RN) is currently on vacation. The nurses perform the CPR, the CNA are certified to perform CPR and could help out with only compressions if needed if there are no additional nurses available at the time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 10:20 AM, the Administrator (NHA) started: I conducted townhall training with all staff. The Risk manager and DON facilitated CPR/DNR trainings and drills-education on policy and procedure on CPR and advanced directives, competency training with nurses, process for initiating code blue, worked with ancillary staff on their roles on how they can help during a code blue. We are continuing with code our code blue drills monthly. The nurses initiate CPR, the CNAs do not perform CPR. The Risk Manager is also the abuse coordinator- the incident that occurred on [DATE] was reported timely as Neglect to all the necessary parties with a follow up 5-day report. We are going to be submitting the 15-day adverse report also due on [DATE]. We conducted an Additional Head of Department Meeting (ADHOC) meeting with the team to identify the root cause analysis of the incident, and work on a plan of correction to be in compliance, and then we take all the information gathered and bring it to Quality Assessment and Performance Improvement (QAPI) team to make sure we review as a team for compliance, we are following protocols and are addressing issues identified accordingly if needed. Interview on [DATE] at 10:53 AM Risk Manager (RM)/Director of Quality Assurance/Abuse Coordinator stated only a licensed nurse can initiate CPR, The CNAs are certified for CPR. They can assist with compressions if needed if no nurses are available in the facility. I filed a report for the incident that occurred with [Resident #1] with DCF (Department of Children and Families), law enforcement and an immediate report with AHCA (Agency for Health Care Administration), notified family and the Medical Director on [DATE]; the NHA was notified by the DON on [DATE]. AHCA five-day report was submitted on [DATE] and depending upon the outcome of the investigation, I prepared an adverse 15-day report to be submitted on [DATE]. As the RM I met with the administrative team to discuss what we were going to put in place to identify other residents that may have been affected and to come up with a plan to address the error. We completed audits to monitor all residents in the facility to make sure their code status was accurate and clearly documented and we are following our policy to make sure a copy of the DNR forms are signed and in the code book located on each nursing unit. We checked the Electronic medical records (EMAR)to make sure the resident's code status were accurately reflected in the EMAR. We conducted an Additional Head of Department Meeting (ADHOC) to make all department heads aware of the problem that exists and the need to implement corrective actions. Part of the implementation is to initiate education to all staff in the facility on Advanced Directives, DNR policy, Code Status policy and each person role that they play when we have a code blue situation in the facility. We also stress the need to do more code blue drills to identify if there is any deficiency in how the drills are performed and to make immediate corrections with staff if needed. The facility's Immediate Jeopardy removal plan included: [DATE]-Resident pronounced deceased at 5:24 AM in the emergency room by Hospital personnel. Review Completed [DATE]-Nurse Practitioner was notified that Resident was transported to the Hospital. Review Completed. [DATE]-Notification of event to Department of Children and Family. Reviewed/completed. Started [DATE]-Ongoing reoccurring training-Education on code status, DNR policy, abuse and neglect policy initiated for current staff. Ancillary team members and CNAs to understand their role during a code blue (taking notes, bringing crash cart, calling 911, clearing hallway for EMS). Reviewed/completed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]-Resident's chart. Reviewed/completed. [DATE]-Audit of medical records to validate DNR/CPR orders. Reviewed/completed. [DATE]-Federal immediate report submitted with notification to DCF. Reviewed/completed. [DATE]-Code books reviewed for accuracy (books located at each nursing station). Reviewed/completed. [DATE]-The nurse involved in the incident was removed from the scheduled pending complete investigation. Reviewed/completed. [DATE]-Current/ongoing, now on monthly cycle-Code blue drills to be performed as follows: every shift x 7 days, then every other day (QOD) on different shift x 7 days, then weekly x 7 days then monthly to include weekends and holidays (starting ,d+[DATE]) on [DATE] until all nurses have attended a code blue drill with no deficiencies. Alternating different scenarios of code status to increase staff understanding. Reviewed/completed. [DATE]-Medical Director notified of events and interventions. [DATE]-[DATE]-Crash carts audited. Reviewed/completed. [DATE]-Nurses' CPR cards audited for validation. Reviewed/completed. [DATE]-ADHOC meeting with Interdisciplinary Team (IDT) and Medical Director. Reviewed/completed. [DATE]-Current/ongoing-Quiz presented to licensed nurses to validate knowledge on code status and procedures. Reviewed/completed. [DATE]- Current/ongoing new admissions/re-admission records to be reviewed daily in morning clinical meetings and on weekends by the Nursing Supervisor for accurate code status. Reviewed/completed. [DATE]-Audit results and outcome of drills to be presented weekly x 3 at Ad HOC meetings. Then monthly in QAPI x 3 months or until compliance to determine the effectiveness of the plan and if revisions to be done as necessary. Reviewed/completed. [DATE]-AHCA Federal five-day report completed. Reviewed/submitted. [DATE]-submit adverse report if applicable. Reviewed investigations findings as of [DATE]. Reviewed/completed. The facility's Removal Plan was verified through observations records reviewed and staff interviews.