STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	518 W Fletcher Ave Tampa, FL 33612

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** 48441 Based on interviews and record review, the facility failed to protect the resident's right to be free from deprivation of goods and services, by staff failing to provide one resident (#1) with Cardiopulmonary Resuscitation (CPR) per the resident's wishes out of eight residents sampled for advance directives. On [DATE] at approximately 3:00 a.m., Resident #1 became unresponsive during routine care. Nursing staff assessed Resident #1 and Emergency Medical Services (EMS) was called to the facility. Prior to EMS arrival, nursing staff reviewed the medical record and determined Resident #1 had a Do Not Resuscitate (DNR) order. Nursing staff provided oxygen at a high concentration via mask, and sternal rubs were intermittently applied with no response from the resident. The EMS team arrived and conducted an initial assessment. Resident #1 was noted with no heart rate and no respirations and was pronounced deceased at 3:29 a.m. At 3:40 a.m., nursing discovered the DNR order in Resident #1's chart belonged to Resident #11, and Resident #1 had an order for Full Resuscitation. 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. Findings Included: A review of the medical record revealed Resident #1 was admitted on [DATE] with diagnoses including encounter for orthopedic aftercare following surgical amputation, Type I Diabetes Mellitus without complications, dysuria, muscle weakness, dysphagia following unspecified cerebrovascular disease, sleep apnea unspecified, obstructive and reflux uropathy unspecified, acquired absence of other right toe(s), and major depressive disorder single episode in full remission. A review of physician orders for Resident #1 showed an order for Full Code, dated [DATE]. A review of Resident #1's care plan, dated [DATE], showed a focus area of advanced directives FULL CODE with an initiated date of [DATE] by the Social Services Director (SSD) and an intervention for this focus area to include: discuss advance directives with resident and or resident's representative. (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	A review of Resident #1's Minimum Data Set (MDS), dated [DATE], Section C- Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact. A review of Section GG-Functional Abilities and Goals Section GG0130-Self-Care showed Resident #1 dependent for toileting and hygiene. A review of Resident #1's 3008/ Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form, dated [DATE], Section H: Advance Care Planning had the following areas checked as NO: Do not Resuscitate, Do Not Intubate, Do Not Hospitalize, No Artificial Feeding and Hospice. A review of Resident #1's medical progress notes, dated [DATE], showed the following: Code Status: Full Code. A review of Resident #11's chart showed an admitted on [DATE], with a discharge date of [DATE]. DNR paperwork was scanned in Resident #11's chart on [DATE]. On [DATE] at 5:00pm., a phone interview was conducted with Staff E, Licensed Practical Nurse (LPN). Staff E, LPN stated, she was working on the east wing on a new admission when she heard a Certified Nursing Assistant (CNA) screaming from the west side needing help. Staff E, LPN along with Staff F, Registered Nurse, (RN) went running over. Staff E, LPN stated two separate blood sugar checks (accucheck) were done with results Around 112 and 117. Staff E, LPN stated, Resident #1 was lying in bed and breathing but Light more SOB [shortness of breath], no suction was required. Staff E, LPN stated, she placed a NRM (non-rebreather mask) on him, and his pulse ox (oximetry) was in the 80's with a heart rate of 77, stating, I remember that. Staff E, LPN stated the resident's nurse (Staff D, LPN) had called 911 and got the paperwork needed to go the hospital, stating, I'm just assuming because she was not in his room. It's normal for the nurse to get the paperwork ready. Staff E, LPN stated, While waiting we were standing by the bedside, pulse ox on right hand, manual blood pressure taken by CNA, but I can't remember who took the blood pressure or what it was. Staff E, LPN stated, Staff G, CNA brought the hard chart and Staff D, LPN looked into the chart. Staff E, LPN stated EMT (Emergency Medical Technicians) arrived 6 minutes later and took over. Staff E, LPN stated the EMT's stated, We can't do CPR if he's breathing, and hooked him up to the machine. Staff E, LPN stated she did not know what the machine showed. Staff E, LPN, stated, Staff D, LPN, said he was a DNR. Staff E, LPN stated, EMT stated, there was nothing they could do. Staff E, LPN stated a discussion was made between the staff and the EMT's regarding transporting the resident to the hospital. Staff E, LPN stated the resident had a peripherally inserted central catheter (PICC), So I figured he must have been treated. Staff E, LPN stated Staff D, LPN was talking to the EMT about being a DNR. Staff E, LPN state Staff D, LPN asked the EMT team why Resident #1 could not go to the emergency room . Staff E, LPN, stated, I felt they were giving us roundabout answers, so I left and ten minutes later I let the EMT team out the door without the resident, no communication from them as what the outcome was. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:17 a.m., an interview was conducted with Staff A, CNA. Staff A, CNA stated on [DATE] she made her rounds to check on her residents and at approximately 12:30 to 12:45 a.m. She stated she changed Resident #1 for incontinence of urine. Staff A, CNA stated, the resident was talking to her. Staff A, CNA stated, she took her lunch break at 2:00 a.m. and clocked back in at 2:30 a.m. and went to room [ROOM NUMBER] to answer the call light and changed both residents in there. Staff A, CNA stated she continued with her rounds and went into Resident #1's room. She stated, He was a little groggy but talking to me. Staff A, stated she rolled Resident #1 to his right, He was talking to me but when I rolled him back onto his back, I noticed something different with him. Staff A stated Resident #1 was not responding to her. She stated she went out and yelled code blue three times. Staff A stated, Staff G, CNA brought the crash cart and went to get the chart. She stated, I was trying to distract his roommate who was waking up. Staff A stated she was not sure who opened the chart but heard someone say Resident #1 was a DNR. She stated, He was breathing though, and someone put a mask on him, and a pulse ox [oximeter] on his finger. I know someone did a sternal rub. I think one of the nurses may have taken his blood pressure but I'm not sure. Staff A, CNA stated she was in the room attending to the roommate but would look over the curtain. Staff A, CNA stated the resident coughed when they did the sternal rub. When the paramedics arrived, she said He stopped breathing. Staff A, stated, the resident's [family member] asked for her to come in when the priest showed up. She stated, It was hard because all my residents are like family to me. On [DATE] at 6:34 a.m., an interview was conducted with Staff B, CNA with Staff C, RN utilized as an interpreter. Staff B, CNA stated, she was working on the west hall when she heard yelling for help from the other hallway. Staff B, CNA stated she ran into the room and there were three nurses in the Resident #1's room (Staff D, LPN, Staff E, LPN and Staff F, RN). Staff B, CNA stated the resident looked pale and witnessed a nurse, Staff F, RN, place a pulse oximeter on the resident's finger and a CNA brought in the crash cart. Staff B, CNA stated, someone put oxygen on the resident and Staff E, LPN squeezed the bag. Staff B, CNA stated the mask had a bag on his chest. Staff C could not recall who called 911. Staff B stated the resident was breathing and had a pulse before the paramedics arrived. Staff B, CNA stated she stayed to see if they needed assistance and when the crash cart arrived, the resident was placed on a back board. On [DATE] at 6:45 a.m., an interview was conducted with Staff G, CNA. Staff G, CNA confirmed she was working [DATE]. Staff G stated on [DATE] at approximately 3:05 a.m., I heard a CNA yell Code Blue. Staff G, CNA stated, she immediately grabbed the code cart and ran it to Resident #1's room. When Staff G, CNA, arrived Staff E, LPN, Staff D, LPN, Staff, F, RN and Staff A, CNA were in the room. Staff G, CNA stated, she pushed the code cart in and went to get the resident's chart. She pulled the chart and started back down the hallway when Staff D, LPN took the chart from her and Staff D, LPN told everyone in the room he was a DNR. When Staff G, CNA got back to the room Staff E, LPN, was doing a sternal rub on the patient. Staff G then left to wait at the door for the EMT's but could not recall when they were called. On [DATE] at 7:11 a.m., an interview was conducted with Staff H, CNA with the assistance of Staff I, RN for interpretation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff H, CNA stated she had worked the evening of [DATE] into [DATE] shift, stating she was working in a resident's room on the east wing, when she heard the code blue. I ran to help the staff. Staff H, CNA stated a nurse had asked her to get the Accu-Check machine. Staff H stated, I don't know names but there were three nurses in the resident's room and one CNA. Staff H, CNA stated, all the staff were taking care of him so I could not really see how he was doing. I went to the door to wait for the EMT to arrive. On [DATE] at 7:29 a.m., an interview was conducted with Staff J, LPN/Unit Manager. (UM). Staff J, LPN/UM stated, she was not here during the event but was on her way to work early. Staff J, LPN/UM stated while on her way, there was a management group text chat which stated Resident #1 had expired. I was like wow. When Staff J arrived at work, the Director of Nursing (DON) was talking to Staff D, LPN, Resident #1's nurse, and the other nursing staff. That's when everything started to come together. Staff J, LPN/UM was told Resident #1 was fine during the cleaning but when Staff A, CNA turned to him onto his back, he wasn't breathing. Staff J stated, EMS was called, and they couldn't revive him. Staff J, LPN/UM stated the family member had been in the facility and had left before she arrived. Staff J, LPN/UM stated the family member called her later in the morning on her cellphone. Staff J, LPN/UM stated, She was like [Staff J] I don't know what happened, I can't believe he's gone. The family member asked me, Can you do me a favor? Staff J, LPN/UM stated the family member asked if she could get a copy of the DNR signed by the resident. Staff J, LPN/UM stated she explained to the family member, she could not do obtain the DNR paperwork but Staff K in social services could assist her. Staff J, LPN/UM stated his family member had stated something was wrong and stated, Staff D, LPN, told me they started CPR and then they stopped because he's a DNR. Staff J, LPN/UM stated the family member had said, Resident #1 and I never signed that paperwork. Staff J, LPN/UM stated when the family member was in the facility, she was looking through the resident's chart and noticed the DNR was of a different resident's name. Staff J, LPN/UM stated, she immediately informed the DON to listen to the remainder of the conversation on her cell phone. The family member wanted a copy of the DNR. Staff J, LPN/UM stated, she told her to come in and talk to the DON and medical records. The DON then took Staff J's cell phone to continue the conversation with the family member. Staff J, LPN/UM stated the family member was asking about the DNR and stated, Maybe [he] signed without my knowledge, but I know [he] would not sign it, he would not even let them take his leg. Staff J stated, once the family member told the DON about this, the DON went to the hard chart and saw the wrong DNR name in the chart. Staff J, LPN/UM stated, I've heard different stories on whether CPR was done. Only one staff member stated CPR was done but must of the staff interviewed stated CPR was not initiated. Staff J, LPN/UM stated, Once you start compressions regardless of DNR status on paper, you must continue with CPR. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:10 a.m., an interview was conducted with Staff J, LPN/UM. Staff J stated, on a newly admitted resident, the nurse will place the resident in the computer as active. After the resident is active, the nurse will assess the resident and input all orders, allergies, code status etc. The nurse will contact the physician and verify the medications. The nurse will let the physician know if the resident decides they want to be a DNR. We will contact the physician and the Social Services Director regarding the resident's code status. Social Services Director is the one who will place the proper paperwork in the chart stating, he's the only one. If the resident comes in with their DNR paperwork it will get uploaded into the chart and placed in front of the hard chart. Staff J, LPN/UM stated, multiple copies are always available in chart. If not, we will get yellow paper from Social Services and make copies. Social Services will come to us with yellow paper if resident is new to DNR and we will place the order in his chart. Staff J, LPN/UM, stated she does not know his process, only what the nursing staff responsibilities. Staff J, LPN/UM stated if a resident states their code status to the staff, the nurse will contact, inform and obtain an order for the Code Status and the nurse will write a note of the conversation with the physician in the progress note. From there, the resident would sign the form if they chose to be a DNR and this form will be faxed or emailed to the physician to sign. Once signed by the physician, the form is faxed or emailed back and social services will place into the hard chart; however, the order was placed in the electronic chart. There may be a short time lapse of twenty-four to forty-eight hours before social services place the yellow DNR paperwork in chart, especially over the weekend, but the staff will have the physician orders to go by. Staff J stated when a resident leaves the facility with plans to return, a bed hold is initiated for seven days, and the hard chart will be saved as is until the resident returns. Staff J stated usually after ten to fourteen days, medical records will take the hard chart of the resident, and a new hard chart would be started upon the resident's return to the facility. On [DATE] at 11:10 a.m., a telephone interview was conducted with Staff A, CNA. She stated, Resident #1 was a diabetic so she thought his sugar may be low, but they did do an accucheck, and it was fine. Staff A, CNA could not recall the time the resident's family member showed up. Staff A, CNA told the family member she did not know what happened. Staff A, CNA told the family member, He was fine when I changed him the first time. Staff A talked to the family member and told her the care provided throughout the night for the resident. Staff A, CNA was answering a call light for another resident, when Staff D, Licensed Practical Nurse (LPN), went and got her after talking to his family member in his room and the family member was requesting to speak with Staff A. Staff A, stated, I don't know what Staff D, LPN and his family member talked about. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:10 p.m., an interview was conducted with the Social Service Director (SSD). The SSD stated he was the Gate keeper and he makes sure the code status regarding medical records is accurate. The SSD stated weekly audits are completed to ensure code status for the residents. The SSD stated, if the resident comes in with a DNR, he will ensure it is legally correct (signatures) and validate with the resident, their desires, etc. On new residents, he would discuss code status. If needed, he would explain in detail what this entails. If the resident would like to become a DNR, he would use a white form of the state Florida 'golden rod' form, have the resident sign and have MD [medical doctor] sign and when completed, copy on to yellow paper. The SSD stated, Then I upload the white form into the electronic medical chart, enter code status into electronic medical record and notify the nursing for transcription of the order into electronic medical record, then I update the Care Plan. The SSD stated, I then place the resident on the ongoing audit form for Advance Directives. The SSD stated the audits are completed weekly, stating, I review the care plan for advance directives, I look for the physical order in the computer and if a DNR is on the chart. The SSD stated, on the morning of [DATE], he noted a white DNR on the chart of Resident #1, and stated, If I put this on the chart it would have been yellow, this was a white form, so I did not do this. The SSD stated, I still have no idea on how the form was in the chart. On [DATE] at 12:15 p.m., a second phone interview was conducted with Staff E, LPN. Staff E, LPN stated Staff D, LPN came into room and stated Resident #1 was a DNR, but I did not see the actual form. Staff E, LPN stated for the EMT to state the resident was a DNR means the DNR form had to have been on yellow paper. Staff E, LPN stated the ambu bag and backboard were out but We never had to use it. Staff E, LPN stated, I assume Staff D. LPN, looked into the electronic medical chart because she had to print the paperwork needed for the EMT team. Staff E stated, the EMT team kept telling us he's a DNR and not to be hospitalized . Staff E, LPN stated, I could not understand that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:45 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, she received a text between 5:00 or 6:00 in the morning from Staff D, LPN, stating, Resident #1 expired. The DON stated she texted her to ask if he was a DNR but Staff D, LPN did not respond back. When she arrived, Staff J, LPN/ UM was in her office on her cell phone. The DON stated she talked to the family member and the family member was inquiring about the DNR stating he was not a DNR. The DON stated the family member said, this was new to me. The DON stated, she would get back with her. The DON then called the Nursing Home Administrator (NHA), to inform the conversation with the family member and Resident #1 was not a DNR. The DON found Staff D, LPN and brought her into my room for an interview. The DON stated Staff D, LPN said the resident died and she had the hard chart with her. The DON stated, she looked and saw a DNR for another resident on white paper in Resident #1's hard chart. The DON stated, At that time I saw the error, we talked about the incident. The DON stated, during my interview with Staff D, LPN, she said the resident was fine during medication administration earlier on her shift until his CNA screamed for help. During her interview, Staff D, LPN, stated to the DON, Staff E, LPN and Staff F, RN were the first to arrive. A glucometer was used by Staff F, LPN and Staff E, LPN put on pulse ox. The DON stated, Staff D, LPN stated, Staff G, CNA brought the crash cart and chart. The DON stated, Staff D, LPN went to get paperwork, and she called 911. A NRM (non-rebreather mask) was placed because of low O2 (oxygen) sat's. The DON stated Staff D, LPN, checked his carotid and said it was in the 70's. Staff D, LPN told the DON, Staff E, LPN gave report to EMT and left, and then Staff D, LPN, gave the paperwork to the EMT's. EMT ran an EKG, stating No mechanical activity. The DON stated, Staff D, LPN, inquired why the EMT would not take him to the hospital because he still has an IV (intravenous) for treatment. Staff D, LPN stated EMT took the paperwork with them. The DON denied seeing a golden rod in the chart/paper. The DON stated Staff L, CNA stated Staff E, LPN handed yellow/brown paper to EMT. The DON stated she suspects the social service assistant uploaded the DNR form into medical records of Resident #11 and then refiled it into the hard chart of Resident #1. The DON stated audits initially were desk reviews but now They have to physically go to each resident's chart. On [DATE] at 2:55 p.m., a phone interview was conducted with the Medical Director (MD) who was Resident #1's primary physician. The MD stated he was contacted on [DATE] at 4:00 a.m., regarding the passing of Resident #1. The MD stated at that time he was unable to recall the code status of the resident but was informed by the caller the resident was a DNR. The MD stated he was informed later Resident #1's chart had the wrong DNR paperwork from another resident with a similar last name. The MD stated resident wishes should be honored and validated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Non-action, which results in emotional, psychological, or physical injury is viewed in the same manner as that caused by improper or excessive action. 1. Screening: The center will ensure that all prospective consultants, contractors, volunteers, caregivers and students are pre-screened as required by law. 2. Training: Employees of the center will receive education and training on Resident Rights, Resident Abuse, and Abuse Reporting during orientation and annually thereafter. Additional education and training will be provided as deemed necessary. 3. Prevention: The center is committed to the prevention of abuse, neglect, misappropriation of resident property, and exploitation. The following systems have been implemented: . Monitoring of residents who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or vulnerable for abuse, for indications of changes in behavior, changes in condition or other nonverbal indication of abuse. A review of the facility's Policy and Procedures titled Resident and Patient Rights, with a revision date of [DATE], showed the following: Policy statement: It is the policy of The Company that all employees will conduct themselves in a professional manner at all times, respecting the rights of each resident or patient to privacy, personal care, self-respect and confidentiality. Procedure: Employees will abide by the requirements for resident rights set forth in federal and state laws and regulations and the company policy and procedure, including the right to a dignified existence, and to be free from verbal, sexual, physical or mental abuse. A review of the facility's Policy and Procedures titled Physician Orders, with a revision date of [DATE], showed the following: Policy: the center will ensure the physician orders are appropriately and timely documented in the medical record. Procedure: Admission Orders: Information received from the referring facility or agency to be reviewed, verified with the physician and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during, or as soon as practicable after it is provided, to maintain an accurate medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105644	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	518 W Fletcher Ave Tampa, FL 33612

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Routine Orders: A nurse may accept a telephone order from the physician, physician assistant (PA) or nurse practitioner (ARNP) as permitted by state law. The order will be repeated back to the physician, PA or ARNP for his/her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMAR or eTAR). The ordering physician or physician extender will review and confirm orders. Confirmation of routine orders requires that the physician sign and date the order as soon as practicable after it is provided to maintain an accurate medical record. Facility immediate actions to correct deficient practice included: o From [DATE] to [DATE], the licensed nurses involved received training regarding verifying resident code status, honoring advanced directives & CPR policy by the Director of Clinical Services (DCS)/Designee o [DATE] Assigned licensed nurse(s) suspended pending investigation. o On [DATE] an AD HOC Quality Improvement Performance Committee meeting was held to review the recommendation made from the root cause analysis. The following team members were in attendance: Medical Director (via telephone), Executive Director, Regional Director of Clinical Services, MDS Coordinator, Unit Manager, Business Development Coordinator, Central Supply, Business Office Manager, Maintenance Director, Activities Director, and Director of Rehab Services. o On [DATE] a full house advance directive audit complete with one isolated finding. o On 08/ ,d+[DATE] The social services department was educated how to properly complete advance directive audits. o On [DATE] education completed with Interdisciplinary team (IDT) on ensuring accurate filing within the medical record. o On [DATE] an addendum to AD HOC Quality Improvement Performance Committee was held to review additional findings from investigation as well as implement further education and audits complete. The following team members were in attendance: Medical Director (via telephone), Executive Director, Regional Director of Clinical Services, MDS Coordinator, Unit Manager, Business Development Coordinator, Central Supply, Business Office Manager, Maintenance Director, Activities Director, and Director of Rehab Services. o On [DATE] The AD HOC QAPI Committee approved the recommendations. o Code Drills were completed 3 times a day on [DATE] [DATE],[DATE],[DATE], 1 completed [DATE], 3 completed on [DATE], 2 completed on [DATE], 2 were completed on [DATE], 1 completed on [DATE] and ongoing. o On [DATE] education provided to Social Services Department on how to properly complete an Advance Directive Audit. o On 08/ ,d+[DATE]-[DATE] all staff (I 00%) received education on Abuse/Neglect/Exploitation and Misappropriation CPR Policy, and Procedures to include drills, Paging System, and Resident Right. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o On [DATE] IDT team was educated on filing of Medical Records. o On [DATE] of 29 licensed nurses received education on Nurse Practice Act and Following Physician Orders. Verification of the facility's removal plan was conducted by the survey team on [DATE] and included the following: A review of education provided to staff included: -Advance Directive dated [DATE] with 100% attendance verification nursing and department heads. -Following Physician Orders, dated [DATE] with 100% attendance verification licensed nursing staff. -Nurse Practice Act Florida dated [DATE] with 100% attendance licensed nursing staff. -Following Care Plans, dated [DATE] with 100% attendance verification all staff. -Paging System dated [DATE] with 100% attendance verification all staff. -Code Blue dated [DATE] with 100% attendance verification all staff. -Resident Rights dated [DATE] with 100% attendance verification all staff. -Abuse, Neglect, Exploitation dated [DATE] with 100% attendance verification all staff. -Clinical Records dated [DATE] with 100% attendance verification from social services. -Advance Directives Audits, DNR, Advance Directive Care Plan dated [DATE] with 100% verification from social services. -Code Blue mock drills immediately initiated on [DATE] to [DATE] and ongoing. -Staff D- investigatory suspension pending determination. -Review of Advance Directives audits [DATE] of the east wing showed 100% compliance and on [DATE] of the west wing showed 100% compliance with identified areas of non-compliance with DNR on yellow form. -On [DATE] at 4:30 p.m., interviews were conducted with 40 staff members individually and in groups on education. Staff members included RN's, LPN's, CNA's, and Social Services and represented multiple shifts. Staff members were able to state education received on Abuse, Neglect and Exploitation (ANE), reporting ANE, Code Status verification, Code Blue/CPR and Resident Rights. Staff members actively participated in the question session. (continued on next page)

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	105644	A. Building B. Wing	08/21/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on verification of the facility's Immediate Jeopardy removal plan, the immediate jeopardy was determined to be removed on [DATE] at 5:00 p.m. and the non-compliance was reduced to a scope and severity of D.

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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** 48441 Based on interviews and record reviews, the facility failed to ensure cardiopulmonary resuscitation (CPR) was performed according to the resident's expressed Advance Directive to honor their rights and professional standards for one resident (#1) out of eight residents reviewed for advance directives. On [DATE] at approximately 3:00 a.m., Resident #1 became unresponsive during routine care. Nursing staff assessed Resident #1 and Emergency Medical Services (EMS) was called to the facility. Prior to EMS arrival, nursing staff reviewed the medical record and determined Resident #1 had a Do Not Resuscitate (DNR) order. Nursing staff provided oxygen at a high concentration via mask, and sternal rubs were intermittently applied with no response from the resident. The EMS team arrived and conducted an initial assessment. Resident #1 was noted with no heart rate and no respirations and was pronounced deceased at 3:29 a.m. At 3:40 a.m., nursing discovered the DNR order in Resident #1's chart belonged to Resident #11, and Resident #1 had an order for Full Resuscitation. 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. Findings Included: A review of the medical record revealed Resident #1 was admitted on [DATE] with diagnoses including encounter for orthopedic aftercare following surgical amputation, Type I Diabetes Mellitus without complications, dysuria, muscle weakness, dysphagia following unspecified cerebrovascular disease, sleep apnea unspecified, obstructive and reflux uropathy unspecified, acquired absence of other right toe(s), and major depressive disorder single episode in full remission. A review of physician orders for Resident #1 showed an order for Full Code, dated [DATE]. A review of Resident #1's care plan, dated [DATE], showed a focus area of advanced directives FULL CODE with an initiated date of [DATE] by the Social Services Director (SSD) and an intervention for this focus area to include: discuss advance directives with resident and or resident's representative. A review of Resident #1's Minimum Data Set (MDS), dated [DATE], Section C- Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact. A review of Section GG-Functional Abilities and Goals Section GG0130-Self-Care showed Resident #1 dependent for toileting and hygiene. A review of Resident #1's 3008/ Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form, dated [DATE], Section H: Advance Care Planning had the following areas checked as NO: Do not Resuscitate, Do Not Intubate, Do Not Hospitalize, No Artificial Feeding and Hospice. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #1's medical progress notes, dated [DATE], showed the following: Code Status: Full Code. A review of Resident #11's chart showed an admitted on [DATE], with a discharge date of [DATE]. DNR paperwork was scanned in Resident #11's chart on [DATE]. On [DATE] at 5:00p.m., a phone interview was conducted with Staff E, Licensed Practical Nurse (LPN). Staff E, LPN stated, she was working on the east wing on a new admission when she heard a Certified Nursing Assistant (CNA) screaming from the west side needing help. Staff E, LPN along with Staff F, Registered Nurse, (RN) went running over. Staff E, LPN stated two separate blood sugar checks (accucheck) were done with results Around 112 and 117. Staff E, LPN stated, Resident #1 was lying in bed and breathing but Light more SOB [shortness of breath], no suction was required. Staff E, LPN stated, she placed a NRM (non-rebreather mask) on him, and his pulse ox (oximetry) was in the 80's with a heart rate of 77, stating, I remember that. Staff E, LPN stated the resident's nurse (Staff D, LPN) had called 911 and got the paperwork needed to go the hospital, stating, I'm just assuming because she was not in his room. It's normal for the nurse to get the paperwork ready. Staff E, LPN stated, While waiting we were standing by the bedside, pulse ox on right hand, manual blood pressure taken by CNA, but I can't remember who took the blood pressure or what it was. Staff E, LPN stated, Staff G, CNA brought the hard chart and Staff D, LPN looked into the chart. Staff E, LPN stated EMT (Emergency Medical Technicians) arrived 6 minutes later and took over. Staff E, LPN stated the EMT's stated, We can't do CPR if he's breathing, and hooked him up to the machine. Staff E, LPN stated she did not know what the machine showed. Staff E, LPN, stated, Staff D, LPN, said he was a DNR. Staff E, LPN stated, EMT stated, there was nothing they could do. Staff E, LPN stated a discussion was made between the staff and the EMT's regarding transporting the resident to the hospital. Staff E, LPN stated the resident had a peripherally inserted central catheter (PICC), So I figured he must have been treated. Staff E, LPN stated Staff D, LPN was talking to the EMT about being a DNR. Staff E, LPN state Staff D, LPN asked the EMT team why Resident #1 could not go to the emergency room . Staff E, LPN, stated, I felt they were giving us roundabout answers, so I left and ten minutes later I let the EMT team out the door without the resident, no communication from them as what the outcome was. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:17 a.m., an interview was conducted with Staff A, CNA. Staff A, CNA stated on [DATE] she made her rounds to check on her residents and at approximately 12:30 to 12:45 a.m. She stated she changed Resident #1 for incontinence of urine. Staff A, CNA stated, the resident was talking to her. Staff A, CNA stated, she took her lunch break at 2:00 a.m. and clocked back in at 2:30 a.m. and went to room [ROOM NUMBER] to answer the call light and changed both residents in there. Staff A, CNA stated she continued with her rounds and went into Resident #1's room. She stated, He was a little groggy but talking to me. Staff A, stated she rolled Resident #1 to his right, He was talking to me but when I rolled him back onto his back, I noticed something different with him. Staff A stated Resident #1 was not responding to her. She stated she went out and yelled code blue three times. Staff A stated, Staff G, CNA brought the crash cart and went to get the chart. She stated, I was trying to distract his roommate who was waking up. Staff A stated she was not sure who opened the chart but heard someone say Resident #1 was a DNR. She stated, He was breathing though, and someone put a mask on him, and a pulse ox [oximeter] on his finger. I know someone did a sternal rub. I think one of the nurses may have taken his blood pressure but I'm not sure. Staff A, CNA stated she was in the room attending to the roommate but would look over the curtain. Staff A, CNA stated the resident coughed when they did the sternal rub. When the paramedics arrived, she said He stopped breathing. Staff A, stated, the resident's [family member] asked for her to come in when the priest showed up. She stated, It was hard because all my residents are like family to me. On [DATE] at 6:34 a.m., an interview was conducted with Staff B, CNA with Staff C, RN utilized as an interpreter. Staff B, CNA stated, she was working on the west hall when she heard yelling for help from the other hallway. Staff B, CNA stated she ran into the room and there were three nurses in the Resident #1's room (Staff D, LPN, Staff E, LPN and Staff F, RN). Staff B, CNA stated the resident looked pale and witnessed a nurse, Staff F, RN, place a pulse oximeter on the resident's finger and a CNA brought in the crash cart. Staff B, CNA stated, someone put oxygen on the resident and Staff E, LPN squeezed the bag. Staff B, CNA stated the mask had a bag on his chest. Staff C could not recall who called 911. Staff B stated the resident was breathing and had a pulse before the paramedics arrived. Staff B, CNA stated she stayed to see if they needed assistance and when the crash cart arrived, the resident was placed on a back board. On [DATE] at 6:45 a.m., an interview was conducted with Staff G, CNA. Staff G, CNA confirmed she was working [DATE]. Staff G stated on [DATE] at approximately 3:05 a.m., I heard a CNA yell Code Blue. Staff G, CNA stated, she immediately grabbed the code cart and ran it to Resident #1's room. When Staff G, CNA, arrived Staff E, LPN, Staff D, LPN, Staff, F, RN and Staff A, CNA were in the room. Staff G, CNA stated, she pushed the code cart in and went to get the resident's chart. She pulled the chart and started back down the hallway when Staff D, LPN took the chart from her and Staff D, LPN told everyone in the room he was a DNR. When Staff G, CNA got back to the room Staff E, LPN, was doing a sternal rub on the patient. Staff G then left to wait at the door for the EMT's but could not recall when they were called. On [DATE] at 7:11 a.m., an interview was conducted with Staff H, CNA with the assistance of Staff I, RN for interpretation. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:45 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, she received a text between 5:00 or 6:00 in the morning from Staff D, LPN, stating, Resident #1 expired. The DON stated she texted her to ask if he was a DNR but Staff D, LPN did not respond back. When she arrived, Staff J, LPN/ UM was in her office on her cell phone. The DON stated she talked to the family member and the family member was inquiring about the DNR stating He was not a DNR. The DON stated the family member said, This was new to me. The DON stated, she would get back with her. The DON then called the Nursing Home Administrator (NHA), to inform the conversation with the family member and Resident #1 was not a DNR. The DON found Staff D, LPN and brought her into my room for an interview. The DON stated Staff D, LPN said the resident died and she had the hard chart with her. The DON stated, she looked and saw a DNR for another resident on white paper in Resident #1's hard chart. The DON stated, At that time I saw the error, we talked about the incident. The DON stated, during my interview with Staff D, LPN, she said the resident was fine during medication administration earlier on her shift until his CNA screamed for help. During her interview, Staff D, LPN, stated to the DON, Staff E, LPN and Staff F, RN were the first to arrive. A glucometer was used by Staff F, LPN and Staff E, LPN put on pulse ox. The DON stated, Staff D, LPN stated, Staff G, CNA brought the crash cart and chart. The DON stated, Staff D, LPN went to get paperwork, and she called 911. A NRM (non-rebreather mask) was placed because of low O2 (oxygen) sat's. The DON stated Staff D, LPN, checked his carotid and said it was in the 70's. Staff D, LPN told the DON, Staff E, LPN gave report to EMT and left, and then Staff D, LPN, gave the paperwork to the EMT's. EMT ran an EKG, stating No mechanical activity. The DON stated, Staff D, LPN, inquired why the EMT would not take him to the hospital because he still has an IV (intravenous) for treatment. Staff D, LPN stated EMT took the paperwork with them. The DON denied seeing a golden rod in the chart/paper. The DON stated Staff L, CNA stated Staff E, LPN handed yellow/brown paper to EMT. The DON stated she suspects the social service assistant uploaded the DNR form into medical records of Resident #11 and then refiled it into the hard chart of Resident #1. The DON stated audits initially were desk reviews but now They have to physically go to each resident's chart. On [DATE] at 2:55 p.m., a phone interview was conducted with the Medical Director (MD) who was also Resident #1's primary physician. The MD stated he was contacted on [DATE] at 4:00 a.m., regarding the passing of Resident #1. The MD stated at that time he was unable to recall the code status of the resident but was informed by the caller the resident was a DNR. The MD stated he was informed later Resident #1's chart had the wrong DNR paperwork from another resident with a similar last name. The MD stated resident wishes should be honored and validated. (continued on next page)

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	105644	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Fletcher	518 W Fletcher Ave Tampa, FL 33612

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:45 p.m., a telephone interview was conducted with Staff D, LPN. Staff D, LPN confirmed she worked on [DATE] on the 11 p.m. to 7 p.m. shift and was assigned to Resident #1. She stated around 1:30 a.m., when completing rounds, Resident #1 was sleeping and breathing, no concerns. She stated around 3:00 a.m., as she was exiting another resident's room, Staff A, CNA was out in the hallway by Resident #1's room calling out for help stating Resident #1 was unresponsive. She stated code blue was called, and staff were responding. She stated Resident #1 was diabetic, Staff E, LPN checked his blood sugar, but it was normal. Staff D, LPN stated she checked his vital signs, and he was breathing. Resident #1's oxygen saturation was in the 70%'s and heart rate 74. She stated Staff E, LPN, put a non-rebreather mask on Resident #1 and his oxygen saturation increased to 87% and his heart rate remained in the 70's. She stated Resident #1 kept breathing but would not verbally respond to staff. She stated she called 911 around 3:,d+[DATE]:05 a.m. She stated she printed his face sheet and physician orders to give to EMS, while Staff E, LPN and the other nurse stayed in the room with Resident #1. She stated Staff G, CNA had retrieved Resident #1 hard chart and gave to Staff E, LPN, It was sitting on the crash cart. She stated Staff G, CNA grabbed the DNR from hard chart. She stated when she saw the yellow paper (DNR form) she didn't confirm the name was Resident #1. She stated EMS arrived 3:,d+[DATE]:15 a.m. and the nurse relayed the situation. She stated Staff E, LPN, gave EMS the yellow paper. She stated that she told EMS that Resident #1 was still breathing and had a pulse, but states EMS said, But he is a DNR and declined to take him to the hospital. Staff D, LPN, stated, in general when you look into the electronic medical record to determine the code status of a resident, is not available. A review of the emergency fire rescue run report, dated [DATE], shows the following: Received 911 alert at 3:13:54 a.m. EMS arrived on [DATE] at 3:20 a.m. Patient contact at 3:22 a.m. Initial assessment of the resident has skin cold, capillary nail bed refill more than 4 seconds, pale with eye bilateral non-reactive and mental status unresponsive. At 3:24 a.m., EKG (electrocardiogram) in 4 leads was in PEA (pulseless electrical activity) which transitioned to asystole (the absence of ventricular contractions leading to imminent cardiac death). Nursing staff reports the patient has a valid DNR, which was requested and has at bedside. Signed and confirmed to be valid per State of Florida with MD (medical doctor) signature. Staff. Patient is unresponsive and has no palpable pulses currently. Patient placed on monitor via cardiac pads, found to be in an idioventricular rhythm with the rate less than 10. A 4-lead EKG monitoring is also placed currently with same findings and EMS crew confirms there is no mechanical pulse currently. Oxygen saturation pulse oximetry on and explain is with no arterial waveform noted. Patient was cool to touch, pale and has no capillary refill noted. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Patient is apneic with a non-rebreather mask on high flow oxygen currently. Patient has no visible chest rise. Shortly after patient is placed on monitor rhythm is noted to be asystole with no electrical or mechanical cardiac activity. Discussion is had with staff members that the patient initially had an idioventricular PEA with no signs compatible with life, to which he is now asystole. Staff confirms that the DNR is active, and patient's wishes are to be granted at this time A yellow copy of valid DNR orders attached to chart. On [DATE] at 3:29 a.m., resident was declared dead. A review of the facility's Policy and Procedure titled Florida Cardiopulmonary Resuscitation (CPR), with a revision date of [DATE], showed the following: Policy statement: cardiopulmonary resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a fully executed Florida do not resuscitate (DNR) order. Procedure: 1. In the event of cardiac arrest, immediately call for assistance. 2. Two licensed nurses are to verify: resident identification Fully executed Florida do not resuscitate order (DH1896), located in the advanced directive section of the medical record 3. Use the paging system and call Code Blue to room number or location of the event three times. 4. In the absence of a fully executed Florida Do Not Resuscitate order (DH1896) the facility will immediately begin CPR. 5. Center staff will continue performing CPR until Emergency Medical Technicians assume responsibility for CPR, or it may be discontinued if: The resident responds. 6. Notify the physician and resident representative/legal representative. 7. Document in the medical record. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Policy and Procedure titled Advance Directives, with a revision date of [DATE], showed the following: Policy statement: The center will abide by state and federal laws regarding advance directives. The center will honor all properly executed advance directives that have been provided by their resident and/or resident representative. Process: 1. Upon admission, Social Service Director or Business Development/designee will: a.) Communicate to resident and/or resident representative his or her right to make choices concerning health care and treatments, including life sustaining treatments. b.) Determine whether the resident has an advanced directive and, if not, determine whether the resident wishes to establish an advance directive. c.) Document in the residence record via the Advanced Discussion Form that the resident and/or resident representative has been apprised of his or her right to formulate an advanced directive. 2. Social services and or business development coordinator designee will assist the resident/ resident representative to complete the advanced directives discussion document. If an advance directive exists the Social Services and/or Business Development Coordinator/designee will obtain a copy and place it in the resident's medical record. 3. If the resident has not executed an advance directive but wishes to establish an advance directive, the Social Service will assist the resident/resident representative with obtaining the state approved advance directive documents formulating an advanced directive is the choice of the resident and is not required. No center employee shall act as a witness or notary for advance directive forms, but staff can assist in ensuring documentation is properly executed period. 4. Upon completion of advanced directives discussion document, social services or nurse will notify the physician of their residence wishes and procure a state approved do not resuscitate order if necessary. Notification will be documented in the medical record. 5. Advanced directives will be reviewed Quarterly Hospice administration Additional times as needed or requested by the resident/resident representative Reviews are designed to: Identify and clarify the content and intent of the existing care instructions, and whether the resident wishes to change or continue these instructions. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Identify situations where health care decision-making is needed. Review the resident's condition, mental capacity to make health care decisions, and existing choices and continue to modify approaches. Any changes to advanced directives will require a new Advanced Directive Discussion Document to be completed and placed in the medical record. The previous document to be filed in the thinned record. 6. Upon notification from resident and/or resident representative of the desire to change or revoke an advance directive, or any issue concerning the capacity, the physician will be notified, and the medical record will be modified accordingly. Facility immediate actions to correct deficient practice included: o From [DATE] to [DATE], the licensed nurses involved received training regarding verifying resident code status, honoring advanced directives & CPR policy by the Director of Clinical Services (DCS)/Designee o [DATE] Assigned licensed nurse(s) suspended pending investigation. o On [DATE] an AD HOC Quality Improvement Performance Committee meeting was held to review the recommendation made from the root cause analysis. The following team members were in attendance: Medical Director (via telephone), Executive Director, Regional Director of Clinical Services, MDS Coordinator, Unit Manager, Business Development Coordinator, Central Supply, Business Office Manager, Maintenance Director, Activities Director, and Director of Rehab Services. o On [DATE] a full house advance directive audit complete with one isolated finding. o On 08/ ,d+[DATE] The social services department was educated how to properly complete advance directive audits. o On [DATE] education completed with Interdisciplinary team (IDT) on ensuring accurate filing within the medical record. o On [DATE] an addendum to AD HOC Quality Improvement Performance Committee was held to review additional findings from investigation as well as implement further education and audits complete. The following team members were in attendance: Medical Director (via telephone), Executive Director, Regional Director of Clinical Services, MDS Coordinator, Unit Manager, Business Development Coordinator, Central Supply, Business Office Manager, Maintenance Director, Activities Director, and Director of Rehab Services. o On [DATE] The AD HOC QAPI Committee approved the recommendations. o Code Drills were completed 3 times a day on [DATE] [DATE],[DATE],[DATE], 1 completed [DATE], 3 completed on [DATE], 2 completed on [DATE], 2 were completed on [DATE], 1 completed on [DATE] and ongoing. (continued on next page)

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