STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105672	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Coast Village	1333 Santa Barbara Blvd Cape Coral, FL 33991

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 - Some	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** 21322 Based on record review, facility's policies and procedures review and staff interviews, the facility failed to ensure staff followed established policies and procedures to honor the advance directives for full code status for 1 (Resident #1) of 3 residents reviewed. On [DATE] at 5:19 a.m., Resident #1 was found unresponsive, without a pulse or respiration. Clinical staff failed to ensure timely confirmation of code status and immediately initiate cardiopulmonary resuscitation (CPR) for Resident #1 who had a full code status. Three Licensed Nurses on duty did not call Emergency Medical Services (EMS) or initiate CPR for 51 minutes while they attempted to locate a non-existent Do Not Resuscitate Order. Resident #1 was pronounced dead by EMS. The failure to honor the residents' right to receive life saving measures, to include CPR, intubation, and defibrillation placed other residents with full code status at a likelihood of serious injury or death and resulted in the determination of Immediate Jeopardy (IJ). On [DATE], after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of [DATE]. The scope and severity were reduced to E, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The findings included: Cross reference to F678, F726, and F835. The facility's policy and procedure titled, Resident's [NAME] of Rights and Dignity Policy with a revision date of [DATE] noted, The resident's bill of rights reflects current federal and state standards governing patient's rights. These rights identify specific prerogatives according to the individual while he/she is a resident at this health care facility. The facility must enforce and ensure resident rights are enforced, including the resident has the right to . self-determination . and access to persons and services inside and outside the facility . The facility must promote and protect the rights of the resident . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Gulf Coast Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 Santa Barbara Blvd Cape Coral, FL 33991	

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's policy and procedure titled, Advance Directive. CPR-Cardiopulmonary Resuscitation Policy. Determining Code Status with a date revised of ,d+[DATE] noted, It is the policy of this facility to honor resident advance directives and provide basic life support, including CPR-Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advance directives . Nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association (AHA) or other approved association unless: A valid Do Not Resuscitate order in place . Every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment . All competent residents have the right to choose or refuse medical treatment during their stay in the facility . Review of the clinical record for Resident #1 revealed an admitted [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease with acute exacerbation. The baseline care plan initiated on [DATE] did not include Advance Directives. The Social Service Admission data collection in the electronic clinical record with an effective date of [DATE] (three days after admission) and did not include advance directives. On [DATE] a physician's progress note noted, Advanced Directives: Full code. On [DATE] at 8:37 a.m., Registered Nurse (RN) Staff A documented in a progress note, This nurse went in to check blood sugar and noted that resident was not responding, at this time I checked for a pulse and respirations. Resident was noted to be with out [sic] pulse and respirations. Then I went to get direction from B wing nurse, then began to look for DNR form when I did not find one I called the PCP (Primary Care Physician) to inform that resident had passed. Next I called the Daughter, then the on call nurse who directed me to call the DON (Director of Nursing). When I spoke with the DON she directed me to start CPR and call 911 when I stated the resident was a full code. At this time, I began CPR and had Cove nurse call 911. On [DATE] at 12:33 p.m., in an interview the Registered Nurse Staff Educator said on [DATE] during morning meeting she found out there was an incident with the process for CPR for Resident #1. From information gathered, CPR was initiated late. She said the nurse on duty did not quite respond and couldn't figure out what to do when she did not find the yellow DNR (Do Not Resuscitate) paper. She was looking for the DNR or Full code or something like that. There was a communication process breakdown. The nurse went to the chart. She found there was no DNR. At this point she did not know what to do so she called the on-call Nurse Manager and also called the DON. She said when a resident is found unresponsive, staff dials (four digit code) from the telephone at the nurse's station to announce a code blue. It is not an overhead page. It will announce on the telephone at each nurse's station. The nurses and CNAs (Certified Nursing Assistants) respond right away. They check the code status by looking in the front of the resident's clinical record for a yellow DNR form. In the absence of a yellow DNR the resident is a full code and they initiate CPR. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 3:01 p.m., the Administrator stated she started an investigation and so far she found out Resident #1 was found unresponsive on [DATE] at 5:19 a.m., and CPR not initiated until [DATE] at 6:10 a.m. The Administrator provided an investigation into Resident #1's delay in receiving lifesaving measures, including CPR which included staff statements, and a timeline of the event which she said she obtained from watching the facility's surveillance video. The investigation noted, At 5:19 a.m. (Staff A) RN (Registered Nurse) went into (Resident #1's room) to check the resident's blood sugar via fingerstick method. She found (Resident #1) unresponsive. She checked for a pulse, no pulse present, sent (Staff D) C.N.A (Certified Nursing Assistant) to get the B (Staff B) and D (Staff C) wing nurses to assist. They checked her code status in EMR (Electronic Medical Record), hard chart and DNR binder, did not see a yellow DNR in the medical record, EMR or DNR binder. (Staff B) went to get the crash cart and CPR was initiated at approximately 06:10am. EMS was called and arrived at 06:24 a.m. and pronounced resident deceased . Delay in the initiation of CPR . Licensed nurses involved suspended pending investigation . A review of Registered Nurse Staff A's statement dated [DATE] noted, I went to check the blood sugar for resident in (Resident #1's room). When I entered the room, I noted the resident was not responding to her name, then rubbed her arm to which did not respond. I then checked for respirations and a pulse which there was none. Resident was noted without pulse and respirations. Then I went to get direction from B wing nurse, then began to look for DNR form. When I did not find one I called the PCP to inform that resident had passed. Next I call the daughter, then the on call nurse who directed me to call the DON. When I spoke with the DON she directed me to start CPR and call 911 when I stated the resident was a full code. At this time, I began CPR and had Cove nurse call 911. A review of Licensed Practical Nurse (LPN) Staff B undated statement noted, At 0530 (5:30 a.m.) or 0540 (5:40 a.m.), A wing nurse came to me for help regarding (Resident #1's room). Walked back to A wing then we checked there was no pulse. We checked code status looked in the chart, there was no code form. Looked in computer, I went to get crash cart. CPR was started when I came to the room. A review of RN Staff C's statement dated [DATE] noted, A wing nurse (RN Staff A) asked me for help around 0520 ish (approximately 5:20 a.m.) stating the patient in (Resident #1's room) was not breathing and had no pulse. I went to Unit and looked for DNR in chart and computer told her to start CPR because she's a full code. I then told her to ask (LPN Staff B) to double check with B wing nurse because he had recently had a death, and he might be able to tell her better. She then went to B wing to ask B wing nurse for help. B wing nurse came to Unit started looking for DNR told him there was no DNR. I then went and checked the patient myself and noted there was no BP (Blood pressure) or pulse. At this point A wing nurse called the DON. DON said to initiate CPR and call 911 and therefore she did. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 2:18 p.m., RN Staff A said in a telephone interview she started employment at the facility on [DATE]. She said on [DATE] at approximately 5:30 a.m., she went in Resident #1's room to do a blood sugar. When she found Resident #1 unresponsive, she went to D wing to get help from RN Staff C. They both started to look for a DNR. They looked in the computer and chart to see if she was a DNR or not. They were not able to find anything. They then went to B wing since that nurse had more experience. LPN Staff B told her not to worry about it, go into the computer or the chart to find out if the resident was hospice. She looked again and couldn't find a DNR. She then drew her own conclusion. She called the resident's daughter, the Unit Manager who was on call and told her to call the DON. She then called the DON who asked if Resident #1 had a DNR. The DON told her if they do not have a yellow DNR form, the resident is a full code. She then told Staff B and Staff C they needed to do CPR. RN Staff A said there was approximately a 15 minutes delay in initiating CPR. Review of the Emergency Medical Services Patient Care Record dated [DATE] noted the call to EMS was received on [DATE] at 6:14 a.m. The EMS Patient Care record documented, Primary impression: Cardiac arrest; Secondary impression: Respiratory arrest. The narrative read, Patient is in cardiac arrest. Nursing home facility staff state that patient was last seen normal around 4:15 this morning. Facility staff stated that when they went to check on her at 5:45 she was found in cardiac arrest. According to facility staff, CPR was delayed until shortly before contacting 911 . Oral tracheal intubation was elected and attempted. While attempting to intubate patient, it was noted patient had rigor mortis (post-mortem stiffening of muscles) to her jaw. Attempt was abandoned and time of death called shortly after. deceased patient was left with NH (Nursing Home) facility RN that was on scene. No further treatment was provided. On [DATE] at 2:04 p.m., in a telephone interview LPN Staff B said on [DATE] he was taking care of a resident on his unit when RN Staff A came to the door and asked him to come and help her. RN Staff A said it was the first time she had someone die. He went in the room and was not able to find a pulse. He went to get the crash cart. He called RN Staff C from another unit. They started CPR and called 911. He said he checked for the code status on the computer and the file. He could not find a DNR. Resident #1 was a full code. He ran to the cart to start CPR. The nurse on duty RN Staff A did not know what to do but he knew what to do. RN Staff C and him did CPR until 911 came. Staff B did not know how long the initiation of CPR was delayed. On [DATE] at 2:48 p.m., in a telephone interview the DON said upon hire, staff receive training on advance directives. She said she has not looked at the training and could not speak to the content. She said the Social Service department was responsible to provide the information to new staff. On [DATE] at 4:58 p.m., in a telephone interview RN Staff C said on [DATE] he was busy taking care of one of his residents when RN Staff A came to ask for help. He said the resident he was taking care of was not in distress. He kept going back and forth between the two residents (his resident and Resident #1). He helped with CPR. He has been employed at the facility for five months, received training related to advance directives and was comfortable with the process. Review of the computer based training for Advance Directives noted a DNRO (Do Not Resuscitate Order) protocol and process that read, Upon admission, the resident and/or resident representative will receive information in regards to advance directives . All valid DNRO Forms . will be kept in front of the resident's chart. If no form in front of the chart resident is a Full code. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the personnel file for RN Staff A, LPN Staff B, and RN Staff C revealed they completed one hour on-line training for Do Not Resuscitate Orders-Florida respectively on [DATE], [DATE], and [DATE]. On [DATE] at 10:22 a.m., in an interview the Staff Social Worker said the Social Service Department was responsible to obtain advance directives upon admission. She said Resident #1 was admitted on a Friday. Since there's no one on the premises from the Social Service department on weekends, she did not meet with Resident #1 until Monday [DATE], three days after her admission. The SSD provided a paper document of section C of the Minimum Data Set which she said was in her office. The words Full and No AD were handwritten on the form. Full was circled. The SSD explained full meant full code and no Ad meant no advance directives. She verified the baseline care plan did not include Resident #1's advance directives and expressed wishes to receive CPR in the event of cardiac or respiratory arrest. She verified the resident's wishes were not documented in the baseline care plan and not available to staff to quickly make the determination to start CPR. The SSD said she did not enter care plans for advance directives until the care plan meeting. On [DATE] at 9:30 a.m., the Administrator verified the clinical staff on duty on [DATE] failed to honor Resident #1's advance directives by failing to immediately initiate lifesaving measures, including CPR in the absence of a DNR per the facility's established policy and procedure. The immediate actions implemented by the facility and verified by the surveyors included: The facility reviewed policies and procedures: [DATE] related to resident rights, Advanced Directives, CPR, DNRO form. On [DATE] and [DATE] the surveyor verified through review of items discussed during QAPI on [DATE] to include a review of the policies and procedures related to Advanced Directives, DNRO and CPR, Code policy procedure. A facility wide assessment was completed on all residents advanced directives. [DATE]. On [DATE] the surveyor verified through review of the facility wide assessment. The facility provided a resident census list with the residents with DNR status highlighted. Three random residents were reviewed for accuracy of code status. The code status was accurate on the audit list for Resident #2, Resident #3, and Resident #4. The facility immediately initiated education on the advanced directives/DNRO process to all staff [DATE]. There are 10 employees that will receive education prior to their next shift. On [DATE] the surveyor verified through review of the in-service education provided to staff. On [DATE] at 4:25 p.m., the Staff educator said the scheduler is to notify them when the staff returns to work. The Unit Manager on that shift will be responsible to ensure the education is done. Ad hoc QAPI conducted on [DATE] at 10:30 a.m. on advanced directives, DNRO, CPR. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Attended: Administrator, DON, Medical Director, Infection Preventionist, Staff Education, Rehab Director, Social Services Director, Social Services Coordinator, Nurse managers (3) Life enrichment Coordinator. Systemic revision made to include Code Drills quarterly with debrief, feedback and plan, introduced a CPR checklist in clinical orientation. Staff notification to supervisor, off hours administration staff is located on the PCC dashboard and the unit information binder. On [DATE] the surveyor verified through observation of the binder located at the nurse's station of the Cove. On [DATE] the surveyor verified through review of the Ad hoc QAPI meeting and review of code drills with debrief form conducted on [DATE], [DATE] and [DATE].

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 21322 Based on record review, facility's policies and procedure reviews and staff interviews the facility staff failed to immediately initiate cardiopulmonary resuscitation (CPR) in the absence of a Do Not Resuscitate (DNR) Order for 1 (Resident #1) of 4 residents reviewed who was found without a pulse or respirations. On [DATE] at 5:19 a.m., Resident #1 was found unresponsive, had no pulse, and no respirations. Clinical staff delayed calling Emergency Medical Services (EMS) and did not initiate CPR for 51 minutes while attempting to locate a non-existent DNR order. CPR is a crucial life-saving technique that aims to sustain blood circulation and oxygenation in individuals experiencing cardiac arrest. Resident #1 was pronounced dead by EMS. The facility's failure to implement their policies and procedures and immediately administer CPR to residents who requires such emergency care placed other residents with full code status at a likelihood of serious injury or death and resulted in the determination of Immediate Jeopardy (IJ). On [DATE] at 11:28 a.m., the facility Administrator was informed of the determination of Immediate Jeopardy and provided the IJ templates. On [DATE], after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of [DATE]. The scope and severity were reduced to E, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The findings included: Cross reference F578, F726 and F835. The facility's policy and procedure titled, CPR-Cardiopulmonary Resuscitation Policy with a reviewed date of , d+[DATE] noted, . Prompt initiation of CPR (cardiopulmonary resuscitation) is essential as brain death begins four to six minutes following cardiac arrest if CPR is not initiated within that time . Purpose. The facility shall provide basic life support, including CPR to a resident who requires such emergency care prior to the arrival of emergency medical services, consistent with the resident's advance directives and physician orders . Procedure . Identify code status/advance directive preferences by checking for a signed DNRO (Do Not Resuscitate Order) form in front of the chart . If no DNR order/advance directive exists or if advance directive does not indicate Do Not Resuscitate, begin resuscitation efforts . Review of the clinical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease with acute exacerbation, and generalized muscle weakness. The physician's orders dated [DATE] did not include a code status. The care plan initiated on [DATE] did not include a code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the physician documented in a progress note, Advanced Directives: Full code. Full code means if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive. This process can include chest compressions, intubation, and defibrillation and is referred to as CPR. On [DATE] at 8:37 a.m., Registered Nurse (RN) Staff A documented in a progress note, This nurse went in to check blood sugar and noted that resident was not responding, at this time I checked for a pulse and respirations. Resident was noted to be with out [sic] pulse and respirations. Then I went to get direction from B wing nurse, then began to look for DNR form when I did not find one I called the PCP (Primary Care Physician) to inform that resident had passed. Next I called the Daughter, then the on call nurse who directed me to call the DON (Director of Nursing). When I spoke with the DON she directed me to start CPR and call 911 when I stated the resident was a full code. At this time, I began CPR and had Cove nurse call 911. Review of the facility's incidents investigations revealed on [DATE] the facility initiated an investigation for a delay of initiating CPR for Resident #1. The investigation noted on [DATE] at 5:19 a.m., RN Staff A went into Resident #1's room to check the resident's blood sugar via fingerstick method. She found Resident #1 unresponsive. She checked for a pulse, no pulse present. She sent Certified Nursing Assistant (CNA) Staff D to get Licensed Practical Nurse (LPN) Staff B and RN Staff C to assist. They checked Resident #1's code status in the Electronic Medical Record (EMR), hard chart and DNR binder, did not see a yellow DNR in the medical record, EMR, or DNR binder. LPN Staff B went to get the crash cart and CPR was initiated at approximately 6:10 a.m. Emergency Medical Services (EMS) was called and arrived at 6:24 a.m. and pronounced Resident #1 deceased . Registered Nurse Staff A documented in a statement dated [DATE], I went to check the blood sugar for resident in (Resident #1's room). When I entered the room, I noted the resident was not responding to her name, then rubbed her arm to which did not respond. I then checked for respirations and a pulse which there was none. Resident was noted without pulse and respirations. Then I went to get direction from B wing nurse, then began to look for DNR form. When I did not find one I called the PCP (Primary Care Physician) to inform that resident had passed. Next I call the daughter, then the on call nurse who directed me to call the DON. When I spoke with the DON she directed me to start CPR and call 911 when I stated the resident was a full code. At this time, I began CPR and had Cove nurse call 911. On [DATE] at 12:33 p.m., in an interview the Registered Nurse Staff Educator said on [DATE] during morning meeting she found out there was an incident with the process for CPR. From information gathered, CPR was initiated late. She said the nurse on duty did not quite respond and couldn't figure out what to do when she did not find a yellow DNR paper. She said, she (RN Staff A) was looking for the DNR or Full code or something like that. There was a communication process breakdown. The nurse went to the chart. She found there was no DNR. At this point she did not know what to do so she called the on-call Nurse Manager and also called the DON. She said when a resident is found unresponsive, staff dials (four digit code) from the telephone at the nurse's station to announce a code blue. It is not an overhead page. It will announce on the telephone at each nurse's station. The nurses and CNAs respond right away. They check the code status by looking in front of the resident's clinical record for a yellow DNR form. In the absence of a yellow DNR the resident is a full code and they initiate CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Nurse Educator said the code status can be checked by anyone, CNAs, nurses, managers from any department, including housekeeping, and maintenance. She said the first thing you see is the yellow DNR form in front of the chart. If there is no yellow DNR, the resident is full code and staff initiates CPR. On [DATE] at 2:18 p.m., in a telephone interview RN Staff A said on [DATE] at approximately 5:30 a.m., she went in Resident #1's room to do a blood sugar. When she found Resident #1 unresponsive, she went to D wing to get help from RN Staff C. They both started to look for a DNR. They looked in the computer and chart to see if she was a DNR or not. They were not able to find anything. They then went to B wing since that nurse had more experience. LPN Staff B told her not to worry about it, go into the computer or the chart to find out if the resident was hospice. She looked again and couldn't find a DNR. She then drew her own conclusion. She called the resident's daughter, the Unit Manager who was on call and told her to call the DON. She then called the DON who asked if Resident #1 had a DNR. The DON told her if they do not have a yellow DNR form, the resident is a full code. She then told Staff B and Staff C they needed to do CPR. RN Staff A said there was approximately a 15 minutes delay in initiating CPR. LPN Staff B documented in an undated statement, At 0530 (5:30 a.m.) or 0540 (5:40 a.m.), A wing nurse (RN Staff A) came to me for help regarding (Resident #1's room). Walked back to A wing then we checked there was no pulse. We checked code status looked in the chart, there was no code form. Looked in computer, I went to get crash cart. CPR was started when I came to the room. On [DATE] at 2:04 p.m., in a telephone interview LPN Staff B said on [DATE] he was taking care of a resident on his unit when RN Staff A came to the door and asked him to come and help her. RN Staff A said it was the first time she had someone die. He went in the room and was not able to find a pulse. He went to get the crash cart. He called RN Staff C from another unit. They started CPR and called 911. He said he checked for the code status on the computer and the file. He could not find a DNR. Resident #1 was a full code. He ran to the cart to start CPR. The nurse on duty RN Staff A did not know what to do but he (LPN Staff B) knew what to do. RN Staff C and him did CPR until 911 came. Staff B did not know how long it took to initiate CPR. On [DATE] at 3:01 p.m., in an interview the Administrator stated based on her investigative findings, Resident #1 was found unresponsive on [DATE] at 5:19 a.m., and CPR was not initiated until [DATE] at 6:10 a.m. She said the findings were based on staff statements and watching the facility's surveillance video. RN Staff C documented in a statement dated [DATE], A wing nurse (RN Staff A) asked me for help around 0520 ish (approximately 5:20 a.m.) stating the patient in (Resident #1's room) was not breathing and had no pulse. I went to Unit and looked for DNR in chart and computer told her to start CPR because she's a full code. I then told her to ask (LPN Staff B) to double check with B wing nurse (LPN Staff B) because he had recently had a death, and he might be able to tell her better. She then went to B wing to ask B wing nurse for help. B wing nurse came to Unit started looking for DNR told him there was no DNR. I then went and checked the patient myself and noted there was no BP (Blood pressure) or pulse. At this point A wing nurse called the DON. DON said to initiate CPR and call 911 and therefore she did. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 3:09 p.m., in an interview CNA Staff E said he has been employed at the facility for less than three months and received orientation. He said the process when a resident is found unresponsive, without a pulse or respiration is to call the nurse. If he couldn't find the nurse, he would go and get the nurse from a different unit. If he couldn't find a nurse he would start CPR by himself. He said he would start CPR no matter what. He said he did not receive training at the facility but knew what to do from previous employment. On [DATE] at 3:15 p.m., CNA Staff F said if she found a resident without a pulse or respiration she would call the nurse. If she cannot find a nurse, she would call 911 first and then tell the nurse manager and they would call the resident's family. She said she would get the nurse manager's number from a book at the nurse's station of the unit. Staff F said they also have a book on the unit with all the yellow DNR forms. On [DATE] at 3:30 p.m., RN Staff G said if a resident is found unresponsive she would call for help, check the code status, and start CPR. When asked about the process to call for help to get assistance, she pulled her personal cellular phone and said she would use it to call someone. There's always someone around on the unit. She said she did not know about the facility's process to dial an established code from the phone to get assistance. She said, To be honest, I don't know. On [DATE] at 3:43 p.m., a mock code drill was observed. The Staff Educator dialed (four digit code) and announced Code Blue three times to room [ROOM NUMBER] B. Staff responded immediately to the room. The Staff Educator was observed coming from B wing nurse's station in the hallway with a green binder to room [ROOM NUMBER] B. From the hallway she yelled, Full code and went back down the hall with the binder. The nurse in the room kept saying, what is the code status? Someone please check the code status after the Staff Educator went back to nursing station, RN Staff G yelled Full code from outside room [ROOM NUMBER]. When asked how she determined the code status, she did not answer. On [DATE] at 4:15 p.m., the Staff Educator provided an evaluation of the code drill which noted, Stop once heard EMS (Emergency Medical Services) arrived. She said during the mock drill staff stopped CPR when they heard EMS had arrived. She explained to them CPR must continue until EMS takes over. On [DATE] at 4:58 p.m., in a telephone interview RN Staff C said on [DATE] he was busy taking care of one of his residents when RN Staff A came to ask for help. RN Staff C said his assigned resident was not in distress but he kept going back and forth between the two residents (his resident and Resident #1). He helped with CPR. RN Staff C said he has been employed at the facility for five months, he received training related to advance directives, including CPR, he knew what to do and was comfortable with the process. On [DATE] at 1:30 p.m., a review of the surveillance video provided by the Maintenance Director showed: On [DATE] at 5:19 a.m., RN Staff A entered Resident #1's room. On [DATE] at 5:20 a.m., RN Staff A came out of Resident #1's room. RN Staff A was seen putting gloves on and walk down the hallway. She walked back toward her medication cart, stopped and was seen looking in another room. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 5:22 a.m., RN Staff A stood at the medication cart for a few seconds then walked toward the nurse's station at the end of the hallway. On [DATE] at 5:23 a.m., RN Staff A and CNA Staff D entered Resident #1's room, followed by an unidentified staff member. On [DATE] at 5:24 a.m., RN Staff A came out of Resident #1's room and walked towards the nurse's station. On [DATE] at 5:25 a.m., RN Staff A walked down the hallway and went back in Resident #1's room. On [DATE] at 5:26 a.m., RN Staff A came out of Resident #1's room and walked down the hallway toward the nurse's station. On [DATE] at 5:27 a.m., RN Staff A and RN Staff C were at the nurse's station. They walked down the hall. RN Staff C entered Resident #1's room, while RN Staff A stood at the medication cart in the hallway across from Resident #1's room. On [DATE] at 5:28 a.m., RN Staff C walked out of Resident #1's room and stood at the medication cart with RN Staff A. RN Staff A was looking through a green binder. CNA Staff D was observed leaving Resident #1's room and walked down the hallway. On [DATE] at 5:28 a.m., CNA Staff D walked back in Resident #1's room. On [DATE] at 5:31 a.m., CNA Staff D walked out of Resident #1's room carrying linen and went down the hall. On [DATE] at 5:32 a.m., RN Staff A walked down the hallway toward the nurse's station. RN Staff C remained standing at the medication cart. On [DATE] at 5:33 a.m., RN Staff C walked in Resident #1's room. On [DATE] at 5:34 a.m., RN Staff A and LPN Staff B walked down the hallway to the medication cart. RN Staff A opened and was turning the pages of a binder with LPN Staff B standing next to her. On [DATE] at 5:35 a.m., RN Staff C walked out of Resident #1's room and stood at the medication cart with RN Staff A and LPN Staff B. LPN Staff B was turning the pages of a green binder. On [DATE] at 5:37 a.m., LPN Staff B walked into Resident #1's room. RN Staff A followed LPN Staff B into the room. RN Staff C remained at the medication cart. On [DATE] at 5:38 a.m., LPN Staff B, and RN Staff A walked out of Resident #1's room, and stood at the medication cart with RN Staff C. On [DATE] at 5:39 a.m., RN Staff A walked down the hallway to the nurse's station, then walked back to the medication cart. LPN Staff B was opening and turning the pages of a green binder. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 5:40 a.m., RN Staff C, and LPN Staff B walked down the hallway to the nurse's station. On [DATE] at 5:42 a.m., RN Staff A walked down the hallway to the nurse's station. On [DATE] at 5:43 a.m., RN Staff A walked back to the medication cart, retrieved a green binder, and walked back to the nurse's station. RN Staff A, LPN Staff B, and RN Staff C stood at the nurse's station. On [DATE] at 5:46 a.m., RN Staff A walked back to the medication cart. On [DATE] at 5:47 a.m., LPN Staff B walked to the medication cart. On [DATE] at 5:48 a.m., RN Staff C, LPN Staff B, and RN Staff A walked down the hallway to the nurse's station. On [DATE] at 5:50 a.m., RN Staff A walked down the hallway to the medication cart. On [DATE] at 5:52 a.m., RN Staff A walked back to the nurse's station. On [DATE] at 6:07 a.m., RN Staff A walked back to the medication cart. On [DATE] at 6:08 a.m., RN Staff A pushed the medication cart down the hallway toward the nurse's station. On [DATE] at 6:09 a.m., LPN Staff B pushed a red cart down the hallway towards Resident #1's room, RN Staff A followed LPN Staff B down the hall. On [DATE] at 6:10 a.m., LPN Staff B walked back to the nurse's station and RN Staff A entered Resident #1's room, followed by CNA Staff D. On [DATE] at 6:11 a.m., RN Staff C entered Resident #1's room. On [DATE] at 6:12 a.m., LPN Staff B entered Resident #1's room. Review of the Emergency Medical Services Patient Care Record dated [DATE] noted the call to EMS was received on [DATE] at 6:14 a.m. The EMS Patient Care record documented, Primary impression: Cardiac arrest; Secondary impression: Respiratory arrest. The narrative read, Patient is in cardiac arrest. Nursing home facility staff state that patient was last seen normal around 4:15 this morning. Facility staff stated that when they went to check on her at 5:45 she was found in cardiac arrest. According to facility staff, CPR was delayed until shortly before contacting 911 . Oral tracheal intubation was elected and attempted. While attempting to intubate patient, it was noted patient had rigor mortis (post-mortem stiffening of muscles) to her jaw. Attempt was abandoned and time of death called shortly after. deceased patient was left with NH (Nursing Home) facility RN that was on scene. No further treatment was provided. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 11:35 a.m., in an interview the Administrator said the nurse is supposed to discuss the code status with the resident upon admission but they do not document it anywhere in the record or on the Electronic Medical Record (EMR). She said the facility's management company does not allow it. She said it was clear in the video footage. The nurses can be seen checking the EMR, and the hard chart and they still did not administer CPR for 51 minutes. She said the standard of practice is, If there is no DNR they have to start CPR. The immediate actions implemented by the facility and verified by the survey team included: The facility reviewed policies and procedures: [DATE] for Advanced directives, DNRO policy and procedure, CPR, Code policy procedure. On [DATE] and [DATE] the surveyor verified through review of items discussed during QAPI on [DATE] to include a review of the policies and procedures related to Advanced Directives, DNRO and CPR, Code policy procedure. The facility immediately reviewed, audited all residents who are considered a full code [DATE]. On [DATE] the surveyor verified through review of the audit completed and comparison of the audit results with random residents chart reviewed. The facility immediately audited and reviewed for completion required onboarding and annual education for Advanced Directives, DNRO policy and procedure and CPR, Code policy and procedure for all staff. [DATE]. On [DATE] the surveyor verified through review of the audit completed, and annual education for Advanced Directives, DNRO policy and procedure and CPR, Code policy and procedure for all staff. Corrective actions for nurses involved includes immediate suspension pending investigation. On [DATE] the surveyor verified through telephone interview of all three nurses involved in the incident on [DATE]. Completed mock code drills on [DATE] at 3:00 p.m., with nine employees responding, [DATE] at 3:43 p.m., with 18 employees responding, [DATE] at 5:40 a.m., with eight employees responding, [DATE] at 11:12 a.m., with 16 employees responding, and 10:08 p.m., with eight employees responding. On [DATE], [DATE], [DATE] and [DATE] the surveyor verified through review of the mock drills completed with critique form. Completed competencies to staff on Code procedure [DATE], [DATE], [DATE]. On [DATE], [DATE] and [DATE] the surveyor verified through review of individual checklist of steps when a resident is found unresponsive and interview of six Licensed Nurses and six Certified Nursing Assistants. Reviewed the orientation and continuing education plan in place for all staff on Advanced Directives, DNRO policy and procedure, CPR, Code policy and procedure [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the surveyor verified through review of the orientation and education plan provided Ad Hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) completed on [DATE] at 10:30 a.m. Attended: Administrator, DON, Medical Director, Infection Preventionist/Staff Educator, Rehabilitation Director, Social Services Director, Social Services Coordinator, Nurse Managers (3), Life Enrichment Director. On [DATE] the surveyor verified through review of the sign-in sheet and items discussed in QAPI and formulation of a Performance Improvement Plan, and interview with the Administrator and the DON.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 21322 Based on observation, record review, facility's policies and procedures review, and staff interview, the facility failed to ensure nursing staff had the appropriate competencies to immediately initiate lifesaving measures, including cardiopulmonary resuscitation (CPR) when residents with full code status experience cardiac or respiratory arrest. On [DATE] at 5:19 a.m., clinical staff found Resident #1 in cardiac and respiratory arrest. Three nursing staff on duty (two Registered Nurses and one Licensed Practical Nurse) delayed the initiation of CPR and the calling for Emergency Medical Services (EMS) for 51 minutes while they attempted to locate a non-existent Do Not Resuscitate Order. Resident #1 was pronounced deceased by EMS. The facility failure to ensure nursing staff were trained and competent in facility's policies related to advance directives, including CPR created a likelihood for residents identified as a full code being denied lifesaving emergency treatment to include CPR, intubation and defibrillation which can result in serious medical injury or death. This failure resulted in the determination of Immediate Jeopardy (IJ) at a scope and severity of pattern (K). On [DATE] at 11:28 a.m., the facility Administrator was notified of the determination of Immediate Jeopardy and provided the IJ templates. On [DATE], after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of [DATE]. The scope and severity were reduced to E no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The findings included: Cross reference F578, F678, and F835. The Gulf Coast Village Facility Assessment revised on [DATE] and reviewed by the Quality Assessment and Quality Assurance and Performance Improvement committed on [DATE] noted, Staff training/education and competencies. On hire mandatory (online training) is completed prior to staff stating on the floor training. They also complete an on-site nursing orientation that includes competencies and scenarios. Clinical checklist are completed upon hire for direct care nursing staff during orientation . Annual skills fairs maintain staff competencies. Drills including . code blue . are facilitated on a schedule throughout the year . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's policy and procedure titled, CPR-Cardiopulmonary Resuscitation Policy with a reviewed date of , d+[DATE] noted, . Prompt initiation of CPR (cardiopulmonary resuscitation) is essential as brain death begins four to six minutes following cardiac arrest if CPR is not initiated within that time . Purpose. The facility shall provide basic life support, including CPR to a resident who requires such emergency care prior to the arrival of emergency medical services, consistent with the resident's advance directives and physician orders . Procedure . Identify code status/advance directive preferences by checking for a signed DNRO (Do Not Resuscitate Order) form in front of the chart . If no DNR order/advance directive exists or if advance directive does not indicate Do Not Resuscitate, begin resuscitation efforts . Review of the facility's incidents investigations revealed on [DATE] the facility initiated an investigation for a delay of initiating CPR for Resident #1. The investigation noted on [DATE] at 5:19 a.m., RN Staff A went into Resident #1's room to check the resident's blood sugar via fingerstick method. She found Resident #1 unresponsive. She checked for a pulse, no pulse present. She sent Certified Nursing Assistant (CNA) Staff D to get Licensed Practical Nurse (LPN) Staff B and RN Staff C to assist. They checked Resident #1's code status in the Electronic Medical Record (EMR), hard chart and DNR binder, did not see a yellow DNR in the medical record, EMR, or DNR binder. LPN Staff B went to get the crash cart and CPR was initiated at approximately 6:10 a.m. Emergency Medical Services (EMS) was called and arrived at 6:24 a.m. and pronounced Resident #1 deceased . On [DATE] at 12:33 p.m., in an interview the Registered Nurse (RN) Staff Educator said on [DATE] during morning meeting she found out about an incident with the process for CPR. From information gathered CPR was initiated late when Resident #1 was found without a pulse or respirations. She said the nurse on duty did not quite respond and couldn't figure out what to do when she did not find a yellow DNR (Do Not Resuscitate) paper. She said, she (RN Staff A) was looking for the DNR or Full Code or something like that. There was a communication process breakdown. The nurse went to the chart. She found there was no DNR. At this point she did not know what to do so she called the on-call Nurse Manager and she also called the DON. The Nurse Educator said the process when a resident is found unresponsive is for staff to dial (four digit code) from the telephone at the nurse's station to announce a code blue. It is not an overhead page. It will announce on the telephone at each nurse's station. The nurses and the Certified Nursing Assistants (CNAs) respond right away. They check the code status by looking in front of the resident's clinical record for a yellow DNR form. In the absence of a yellow DNR the resident is a full code and they initiate CPR. She said the code status can be checked by anyone, CNAs, nurses, managers from any department, including housekeeping and maintenance. If there is no yellow DNR from in front of the chart, the resident is a full code and staff initiates CPR. She said RN Staff A did not follow the process. The Staff Educator said since the incident, she started educating the staff about the process and conducted a code blue drill since the incident. She provided a sign-in sheet for a topic of, Code Blue Drill dated [DATE] at 3:00 p.m. The form was signed by three therapists, one receptionist, two Certified Nursing Assistants, one Registered Nurse and two Licensed Practical Nurses. The form did not describe the content of the drill, or an evaluation of the response to the drill. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Nurse Educator said she did not document the staff response to the drill but there were some areas for improvement, not everyone responded or signed the form. On [DATE] at 2:48 p.m., in a telephone interview the Director of Nursing said she has been employed at the facility for one year. The initial training for Advance Directives and Code status is done in general orientation. She said the licensed nurses all went to school and also have the CPR certification verifying they are competent. The facility tells them where to get the DNR information. The process for DNR is done by the Social Worker during orientation. She said she has not looked at the content of the training. Everything is kept by the facility's management company. She said the Regional Nurse Consultant conducts code blue drills periodically but she did not know how often they were done. When asked how she verified the competency of the nursing staff to respond appropriately when a resident is found unresponsive, the DON said she's had conversations with all the nurses to make sure they know what to do if a resident is found unresponsive but since it's not documented anywhere, so it didn't happen. Review of the employee file for Registered Nurse Staff A revealed a date of hire of [DATE]. Review of the training transcript showed on [DATE] Staff A completed one hour of online training on Do Not Resuscitate Orders and 30 minutes training on Essential of Resident Rights. A Basic Life Support certificate with an issue date of [DATE] and a renew by date of ,d+[DATE] noted Staff A had successfully completed basic life support program. The employee file did not include a competency checklist for Registered Nurses. It included a competency checklist for Certified Nursing Assistant dated [DATE]. The competency/skills verification included the location of the crash cart and AED (Automated External Defibrillator). The checklist did not include a competency evaluation of Staff A's response in the event a resident is found unresponsive. On [DATE] at 2:18 p.m., in a telephone interview RN Staff A said the training she received during orientation included CPR and DNR but in her opinion, it wasn't extensive and was not very good. She said on [DATE] at approximately 5:30 a.m., she found Resident #1 unresponsive. She knew the first step was to find out is Resident #1 was a DNR. She went to D wing to get help from RN Staff C. They both looked in the chart and the computer but could not locate a DNR. They then went to B wing nurse to get help from LPN Staff B since he had more experience. They could not find a DNR. RN Staff A said she drew her own conclusion, called the resident's daughter, the Unit Manager on call and told them Resident #1 had expired. RN Staff A said she just got her nursing license. She said, they left three brand new nurses alone at night. She said she felt it was not safe, and the information provided was not clear enough. She needed to figure out for herself what to do. Review of the Florida Department of Health license verification website revealed RN Staff A's original license issue date was [DATE]. Review of the personnel file for LPN Staff B revealed a date of hire of [DATE]. Review of the training transcript showed on [DATE] Staff B completed one hour of online training on Do Not Resuscitate Orders and on [DATE] completed 30 minutes training on Essential of Resident Rights. A certificate of completion dated [DATE], noted Staff B successfully completed, and was certified in standard CPR/AED. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The personnel file contained a Certified Nursing Assistant competency checklist dated [DATE]. The competency/skills verification included the location of the crash cart and AED (Automated External Defibrillator). The checklist did not include an evaluation of Staff B's response in the event a resident is found unresponsive. On [DATE] at 2:04 p.m., in a telephone interview LPN Staff B said on [DATE] he was taking care of one of his residents when RN Staff A came to the door and asked him to come out to help her. He said he went in Resident #1's room. She did not have a pulse. RN Staff A said she did not know what to do. He called RN Staff C from another unit. He checked for the code status in the computer and in the file. He did not find a DNR. She was a full code. That's why he ran to the cart to start CPR. LPN Staff B said he works at night. He had three or four days of training. He said he did not know what happens during the day but at night there has been no training or code blue drill. He knew where the crash cart was because he's seen it. Review of the personnel file for RN Staff C revealed a hire date of [DATE]. Review of the training transcript showed on [DATE] Staff C completed one hour of online training on Do Not Resuscitate Orders and 30 minutes training on Essential of Resident Rights. The RN competency checklist signed by the Registered Nurse Consultant on [DATE] was not signed by RN Staff C. A certificate of completion dated [DATE], noted Staff C successfully completed, and was certified in Basic Life Support. On [DATE] at 3:01 p.m., the Administrator said, The nurses are nurses, had CPR certification and passed board. She said they were all CPR certified and it was not the facility's responsibility to teach them CPR. The Administrator looked at the competency checklist for RN Staff A and said she thought it included what to do when a resident is found unresponsive. On [DATE] at 3:09 p.m., in an interview CNA Staff E said he has been employed at the facility for less than three months and received orientation. He said the process when a resident is found unresponsive, without a pulse or respiration is to call the nurse. If he couldn't find the nurse, he would go and get the nurse from a different unit. If he couldn't find a nurse he would start CPR by himself. He said he would start CPR no matter what. He said he did not receive training at the facility but knew what to do from previous employment. On [DATE] at 3:15 p.m., CNA Staff F said if she found a resident without a pulse or respiration she would call the nurse. If she cannot find a nurse, she would call 911 first and then tell the nurse manager and they would call the resident's family. She said she would get the nurse manager's number from a book at the nurse's station of the unit. Staff F said they also have a book on the unit with all the yellow DNR forms. On [DATE] at 3:30 p.m., RN Staff G said if a resident is found unresponsive she would call for help, check the code status, and start CPR. When asked about the process to call for help to get assistance, she pulled her personal cellular phone and said she would use it to call someone. There's always someone around on the unit. She said she did not know about the facility's process to dial an established code from the phone to get assistance. She said, To be honest, I don't know. (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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 3:43 p.m., a Code Blue drill was observed in room [ROOM NUMBER] B. The Staff Educator dialed (four digits code) and announced Code Blue three times to room [ROOM NUMBER] B. Staff responded immediately to the room. The Staff Educator was observed coming from B wing nurse's station in the hallway with a green binder to room [ROOM NUMBER] B. From the hallway she yelled, Full code and went back down the hall with the binder. The nurse in the room kept saying what is the code status, someone please check the code status after the staff educator went back to nursing station. RN Staff G yelled Full code from the hallway. When asked how she determined the code status, she did not answer. On [DATE] at 4:15 p.m., the Staff Educator provided an evaluation of the drill which noted, Stop once heard EMS arrived. The Staff Educator said during the mock drill staff stopped CPR when they heard EMS had arrived. She explained to them CPR must continue until EMS takes over. On [DATE] at 4:58 p.m., in a telephone interview RN Staff C said on [DATE] he was on duty when RN Staff A came to ask for help. He said he received training on CPR/DNR which included what to do when a resident is found unresponsive. He said he did not remember participating in any code blue drills. He said he was busy taking care of one of his resident and kept going back and forth between his resident and Resident #1. He said his assigned resident was not in distress but he kept going back and forth between the two residents. He helped with CPR. On [DATE] at approximately 7:30 a.m., in an interview Licensed Practical Nurse (LPN) Staff H said a long time ago they used to receive in-services related to CPR, DNR. She said, Now they just put a paper in front of you and tell you to sign it. They don't explain anything. She said there are a lot of new graduates working the night shift. They do not know what to do and are left without supervision. She said they eliminated the night shift supervisor. She told the DON they were endangering the residents' lives. On [DATE] at 10:22 a.m., in an interview the Manager on Duty verified she was on call on [DATE] when Resident #1 passed away. She said RN Staff A called her at 6:00 a.m. and told her Resident #1 had died . Staff A was upset, she was crying. She said it was the first time she experienced a death. She had to tell her to calm down and breathe. Staff A told her Resident #1 was a Full Code. She asked specifically if she initiated CPR and called EMS, Staff A said, Yes. She then directed her to call the DON. When she came to work later that day the DON informed her Staff A never started CPR. On [DATE] at 10:59 a.m., in a telephone interview the Regional Nurse Consultant said the last mock code was done in [DATE] but she did not have the documentation. The immediate actions implemented by the facility and verified by the survey team included: The facility reviewed policies and procedures: [DATE] for Advanced directives/DNRO policy and procedure, CPR/Code policy and procedure. On [DATE] the surveyor verified through review of documentation the policies and procedures were reviewed. The facility immediately reviewed/audited all resident who are a full code [DATE]. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the surveyor verified through review of audits and compared with five random residents records for accuracy, residents #2, #3, #4, #5, #6. The facility immediately audited and reviewed for completion of the required onboarding and annual education for Advanced Directives/DNRO policy and procedure and CPR/Code policy and procedure for all staff. On [DATE] the surveyor verified through review of plan for onboarding and annual education. The facility immediately reviewed CPR certifications for all appropriate staff. [DATE]. On [DATE] the surveyor verified through review of a sample of five nurses and five CNAs for CPR certification. The facility immediately provided education: Advanced Directives/DNRO policy and procedure, CPR/ code policy and procedure. [DATE]. On [DATE] the surveyor verified by review of the education provided and interview of four nurses and four CNAs. Administrator educated Social Services Director on determining code status on admission within 48 hours. Admissions RN will assist with this process. On [DATE] the surveyor verified through review of education provided and verification of code status for five new residents admitted within 48 hours, and documentation in baseline care plan. Corrective actions for nurses involved included immediate suspension pending investigation. [DATE]. On [DATE] the surveyor verified through review of schedule and telephone interview with the three nurses involved. Completed mock code drills on [DATE] at 3:00 p.m. with nine employees responding, [DATE] at 3:43 p.m. with 18 employees responding, [DATE] at 5:40 a.m., with eight employees responding, [DATE] at 11:12 a.m. with 16 employees responding and 10:08 p.m. with eight employees responding. On [DATE] the surveyor verified through review of the documentation of the mock drills and documented response to the mock drills. Completed competencies to staff on Code procedure [DATE], [DATE], [DATE]. On [DATE] the surveyor verified through review of the signed individual step by step procedure when a resident is found unresponsive. On [DATE] five licensed nurses and five CNAs interviewed were able to describe the process to follow when a resident is found unresponsive. Reviewed the orientation and continuing education plan in place for all staff on Advanced Directives/DNRO policy and procedure, CPR/Code policy and procedure [DATE]. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the surveyor verified through review of the education plan and policies and procedures. Systemic revision made to include Code Drills quarterly with debrief, feedback and plan, introduced a CPR checklist in clinical orientation. On [DATE] the surveyor verified through review of the mock code drills with debrief and review of the CPR checklist in clinical orientation.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21322 Based on observation, record review and staff interview, the facility's Administration failed to utilize its resources effectively by failing to ensure staff was adequately trained and knowledgeable in policies and procedures to honor residents' rights to advance directives, including the right to receive cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. On [DATE] at 5:19 a.m., Resident #1 was found without pulse or respiration. The clinical staff on duty did not initiate CPR until 6:10 a.m., 51 minutes after Resident #1 was found unresponsive. Resident #1's wishes to be a full code and receive CPR was not documented in the baseline care plan, despite the Social Services Department being aware of the resident's full code status on [DATE]. Resident #1 was pronounced dead by Emergency Medical Services. The facility's failure to manage resources to ensure staff are aware of and honor a resident's expressed advance directives created a likelihood for residents to be identified as a full code being denied lifesaving emergency treatment to include CPR, intubation and defibrillation which can result in serious medical injury or death. This failure resulted in the determination of Immediate Jeopardy (IJ) as a scope and severity of pattern, (K). On [DATE] at 11:28 a.m., the Administrator was notified of the determination of Immediate Jeopardy and provided the IJ templates. On [DATE], after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of [DATE]. The scope and severity were reduced to E, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The findings included: Cross reference F578, F678, and F726. The Administrator's job description signed by the Administrator on [DATE] noted the Administrator provides the management expertise for achieving the goals and objectives of the program in accordance with the mission of the organization. The Administrator should develop an organizational plan that clearly assigns responsibilities for the program's services to functional departments and to individuals. The Administrator should develop, recommend, and implement a plan for continuity that ensures ongoing stability of the program. Such a plan should include performance standards that are stated in terms of continuous improvement targets, opportunities for internal and external development, and a system for evaluating the performance levels of all employees, consultants, and other service providers. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing job description signed by the Director of Nursing on [DATE] noted the Director of Nursing is responsible for ensuring that an adequate level of services is provided to each resident, documented appropriately and regularly evaluated. Instruct staff on various federal, state and facility's regulations, policies and procedures; monitors compliance. Delivery of Nursing Services: Analyzes and evaluates nursing care and related ancillary and therapeutic services rendered to improve quality of patient care and to plan the best utilization of staff time and activities. Develops, monitors, and maintains required and appropriate documentation on the residents' medical records to include a multi-disciplinary plan of care. Review of the facility's incidents investigations revealed on [DATE] the facility Administrator initiated an investigation for a delay of initiating CPR for Resident #1. The investigation noted on [DATE] at 5:19 a.m., RN Staff A went into Resident #1's room to check the resident's blood sugar via fingerstick method. She found Resident #1 unresponsive. She checked for a pulse, no pulse present. She sent Certified Nursing Assistant (CNA) Staff D to get Licensed Practical Nurse (LPN) Staff B and RN Staff C to assist. They checked Resident #1's code status in the Electronic Medical Record (EMR), hard chart and DNR binder, did not see a yellow DNR in the medical record, EMR, or DNR binder. LPN Staff B went to get the crash cart and CPR was initiated at approximately 6:10 a.m. Emergency Medical Services (EMS) was called and arrived at 6:24 a.m. and pronounced Resident #1 deceased . On [DATE] at 3:48 p.m., the Administrator documented in the incident investigation, Determined that the licensed staff involved failed to honor resident's advanced directives as a full code in a timely manner . Conclusions: It is verified that the licensed staff involved delayed the provision of CPR. On [DATE] at 12:33 p.m., in an interview the Registered Nurse Staff Educator said on [DATE] during morning meeting she found out there was an incident with the process for CPR. From information gathered, CPR was initiated late. She said the nurse on duty did not quite respond and couldn't figure out what to do when she did not find a yellow DNR paper. She said, she (RN Staff A) was looking for the DNR or Full code or something like that. There was a communication process breakdown. The nurse went to the chart. She found there was no DNR. At this point she did not know what to do so she called the on-call Nurse Manager and also called the DON. She said when a resident is found unresponsive, staff dials (four digit code) from the telephone at the nurse's station to announce a code blue. It is not an overhead page. It will announce on the telephone at each nurse's station. The nurses and CNAs respond right away. They check the code status by looking in the front of the resident's clinical record for a yellow DNR form. In the absence of a yellow DNR the resident is a full code and they initiate CPR. The RN Staff Educator said the code status can be checked by anyone, CNAs, nurses, managers from any department, including housekeeping, and maintenance. She said the first thing you see is the yellow DNR form in front of the chart. If there is no yellow DNR, the resident is full code and staff initiates CPR. The Staff Educator said since the incident, she started educating the staff about the process and conducted a code blue drill since the incident. At this time, she provided a sign-in sheet for a topic of, Code Blue Drill dated [DATE] at 3:00 p.m. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:59 a.m., in a telephone interview the Regional Nurse Consultant said the last mock code drill was done in [DATE] but she did not have the documentation. The Registered Nurse Consultant said they do not use the term Code Blue when a resident is found unresponsive, staff has to call for help. She said last March she remember conducting some mock code drills when the facility had an interim Director of Nursing. They covered all shifts on all units. She said they went through two other staff educators and did not know where the documentation of the mock drills went. On [DATE], review of the clinical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease with acute exacerbation, and generalized muscle weakness. The physician's orders as of [DATE] did not include a code status. The care plan initiated on [DATE] did not include a code status. On [DATE] the physician documented in a progress note, Advanced Directives: Full code. Full code means if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive. This process can include chest compressions, intubation, and defibrillation and is referred to as CPR. On [DATE] at 10:22 a.m., in an interview the Staff Social Worker verified Resident #1's advance directives and code status were not documented in the baseline care plan. She said Resident #1 was admitted on a Friday. No one from the Social Service department work on weekends therefore she did not meet with Resident #1 until [DATE], three days after admission. Upon request for documentation of Resident #1's advance directives discussion, the Social Worker said the documentation was on a paper form kept in her office. She brought back a paper copy of section C of the Minimum Data Set Assessment with the word Full circled which she said meant full code and No AD which she said meant no advance directives. She verified the information of Resident #1's code status was not documented in the baseline care plan and not available to staff on [DATE] when Resident #1 was found unresponsive. On [DATE] at 11:35 a.m., in an interview the Administrator said the nurse is supposed to discuss the code status on admission with the resident but they do not document it anywhere in the clinical record or the electronic record. She said in the surveillance video, you can see the nurses checking the electronic record, the hard chart and they still did not administer CPR to Resident #1 for 51 minutes. The immediate actions implemented by the facility and verified by the survey team included: The facility reviewed policies and procedures for Advanced directives/DNRO policy and procedure, CPR/Code policy and procedure. On [DATE] the surveyor verified through review of documentation of facility's policies and procedures review. Administrator and DON educated by Clinical consultant on Advanced Directive/DNRO policy and procedure, CPR/Code policy and procedure [DATE]. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the surveyor verified through review of education provided and interview with the Administrator and the DON during a review of Quality Assurance and Performance Improvement process. The facility immediately reviewed/audited all residents who are considered a full code. [DATE]. On [DATE] the surveyor verified through review of the audits completed. The facility immediately audited and reviewed for completion required onboarding and annual education for Advanced Directives/DNRO policy and procedure and CPR/Code policy and procedure for all staff. [DATE]. On [DATE] the surveyor verified through review of the facility's audits of completion of onboarding and annual education for advance directives, DNRO policy and procedure and CPR/Code policy and procedure for all staff. The facility immediately reviewed CPR certifications for all appropriate staff [DATE]. On [DATE] the surveyor verified through review of CPR certification provided for licensed nurses and CNAs. The facility immediately provided education: Advanced Directives/DNRO policy and procedure, CPR/Code Policy and procedure. [DATE]. On [DATE] the surveyor verified through review of education provided for five licensed nurses and five CNAs. Corrective actions for nurses involved included immediate suspension pending investigation [DATE]. On [DATE] the surveyor verified through review of the staffing schedule, and on [DATE] by telephone interview with the three nurses involved. Completed mock code drills on [DATE] at 3:00 p.m. with nine employees responding, [DATE] at 3:43 p.m. with 18 employees responding, [DATE] at 5:40 a.m., with eight employees responding, [DATE] at 11:12 a.m. with 16 employees responding and 10:08 p.m. with eight employees responding. On [DATE] the surveyor verified through review of the documentation of the mock drills and documented response to the mock drills. Completed competencies to staff on Code procedure [DATE], [DATE], [DATE]. On [DATE] the surveyor verified through review of the signed individual step by step procedure when a resident is found unresponsive. On [DATE] five licensed nurses and five CNAs interviewed were able to describe the process to follow when a resident is found unresponsive. Reviewed the orientation and continuing education plan in place for all staff on Advanced Directives/DNRO policy and procedure, CPR/Cod policy and procedure [DATE]. On [DATE] the surveyor verified through review of the education plan and policies and procedures. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ad Hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) completed on [DATE]. On [DATE] the surveyor verified through review of the Ad Hoc QAPI meeting and attendance sign in sheet. On [DATE] the surveyor verified through interview with the Administrator, DON and telephone interview with the Medical Director.