STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105735	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orange City Nursing and Rehab Center	2810 Enterprise Rd Debary, FL 32713

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident records, the facility's policy and procedure for Advance Directives, facility reports, and interviews with staff, the facility failed to act in accordance with the resident's Advance Directives in accordance with her Do Not Resuscitate (DNR) status (the desire have cardiopulmonary resuscitation (CPR) withheld in the event that her heart or breathing stopped) after finding her unresponsive with no respirations. This affected one (Resident #1) of nine residents reviewed for Advance Directives. The facility's failure to review and honor Resident #1's DNR status deprived her of a natural death and likely caused unnecessary pain and bodily damage. Resident #1 expired in the hospital after prolonged life-sustaining efforts had been made and her family discontinued her from life support. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 1:59 p.m. on [DATE]. On [DATE] at 3:06 p.m., Immediate Jeopardy began. On [DATE] at 2:50 p.m., the Administrator was notified of the IJ determination, IJ Templates were provided, and Immediate Jeopardy was removed, effective [DATE]. The facility remained out of compliance, and after verification of the removal of immediate jeopardy, the scope and severity were reduced to D, no actual harm, with a potential for no more than minimal harm, due to the facility's nursing staff having provided cardiopulmonary resuscitation (CPR) to a resident with a Do Not Resuscitate (DNR) order. The findings include: Cross reference F678 A closed record review for Resident #1 found she was admitted from the hospital on [DATE]. Her diagnoses included, but were not limited to, toxic encephalopathy (brain dysfunction caused by toxic exposure), other neurological conditions, atrial fibrillation (irregular heartbeat that often causes poor blood flow), hypertension, diabetes mellitus, dementia, malnutrition, and chronic obstructive pulmonary disease/asthma. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 had a Modification of a Discharge/Return Anticipated Minimum Data Set (MDS) assessment with an assessment reference date of [DATE], which revealed admission from a short-term acute care hospital on [DATE]. Resident #1 had an unplanned discharge on [DATE] back to an acute care hospital. She was assessed as being independent with daily decision making and required supervision to partial assistance with activities of daily living. Active discharge planning was occurring for Resident #1 to return to the community. Resident #1 was care planned on [DATE] for short-term care and discharge to home, with the goal to verbalize required assistance post-discharge and the services required to meet her needs before discharge. Interventions included: . Resident has been informed of their right to participate in establishing the expected goals and outcomes of care . to be informed, in advance, of changes to the plan of care . Resident has been informed of their right to request, refuse and/or discontinue treatment . Short Term Care. (Photographic evidence obtained) Resident #1 was care planned on [DATE] for Advance Directives in place, however, no code status was noted. A revision to the care plan, dated [DATE], two weeks after her discharge, noted she was a Full Code. The goal was for Resident #1's Advance Directives to be honored by staff. Interventions contradicted the focus area and noted she had a DNR. (Photographic evidence obtained) The resident's electronic medical record (EMR) contained a Florida DNR form which was signed by the resident and her physician on [DATE]. There was a corresponding physician's order for DNR dated [DATE]; however, this order was discontinued on [DATE] at 3:06 p.m. by Licensed Practical Nurse (LPN) A. The reason for discontinuing the DNR order was noted as DC (discharge) home. (Photographic evidence obtained) On [DATE] at 6:38 p.m., LPN A entered an order for Full Code in the resident's medical record. (Photographic evidence obtained) Resident #1 was last seen by the Advanced Practice Registered Nurse (APRN) on [DATE] for discharge planning. The APRN noted Resident #1 reported no concerns and was medically stable at this time. (Photographic evidence obtained) Nursing progress notes revealed that on [DATE], Resident #1 was alert and oriented x3 (to person, place, and name). On [DATE], she was noted to be disoriented x3 and alert but lethargic. A nursing progress note, dated [DATE] at 5:10 a.m. by Registered Nurse (RN) B, reported a certified nursing assistant (CNA) came to him to report that Resident #1 was not breathing. RN B checked for the resident's pulse and it was absent. The nurse assigned to the other medication cart called 911, called a Code Blue, and got the crash cart. A subsequent note authored by RN B on [DATE] at 5:18 a.m., reported that emergency medical technicians (EMTs) arrived with the fire department, assessed the resident, and started [chest] compressions. At 5:42 a.m., the EMTs left the facility with Resident #1. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a facility report, generated on [DATE], revealed that on [DATE] at approximately 5:15 a.m., Resident #1 was found unresponsive by CNA K. She notified RN B, who observed the resident without a pulse or respirations and resuscitation was performed per the active physician's order by RN B, LPN C and LPN E. It was discovered by RN D, through conversation with a family member and review of the Florida goldenrod form, that Resident #1 had a Do Not Resuscitate (DNR) order. Resident #1 expired at the hospital at 8:33 a.m. A staff member (LPN A) had inadvertently discharged Resident #1 on [DATE]. Upon immediately realizing her mistake, she reinstated all discharged orders but inadvertently reinstated a Full Code status instead of DNR. The facility's analysis of the incident noted its investigation verified unintentional neglect. Resident #1 had been admitted to the facility on [DATE]. On [DATE], CNA K entered Resident #1's room to provide morning care to Resident #1's roommate. When she went to see Resident #1, the resident was unresponsive. CNA K immediately notified RN B, who assessed Resident #1 and found she had no pulse or respirations. RN B checked Resident #1's code status in the electronic medical record and found orders for Full Code. He then requested CNA K retrieve the crash cart and notify LPN C to call a Code Blue overhead. RN B initiated CPR per the orders in the EMR since Resident #1 was unresponsive and without signs of rigor or advanced death. LPN C called 911, then assisted LPN E and RN B until EMTs arrived and took over resuscitation. Resident #1 was taken to the hospital at 5:18 a.m. with the [NAME] Chest Compression System (mechanical chest compression device) in process. At 9:00 a.m., the weekend supervisor, RN D, was attempting to contact Resident #1's primary contact, since the prior phone call made by LPN C had not been returned. Another family member answered the phone and reported Resident #1 had a DNR code status and the family had given these documents to the facility upon her admission. RN B reviewed the medical record and confirmed the presence of the DNR. While reviewing the medical record, the Director of Nursing (DON) and RN D identified that Resident #1 had been mistakenly discharged from the EMR on [DATE] by LPN A. She had inadvertently discharged Resident #1 instead of a different resident with a similar name. LPN A caught her mistake immediately on [DATE] and re-entered Resident #1's physician's orders into the EMR. While doing so, she transcribed the code status as Full Code when it should have been Do Not Resuscitate. Psychological harm to the resident's family was identified during an interview with Resident #1's family member on [DATE] at 12:15 p.m. The family member stated Resident #1 was admitted to the facility with an active DNR order. For some reason on the day of the event, nobody saw it so it was not honored. It was a mistake and the facility apologized. Between facility and hospital staff, they spent an hour resuscitating Resident #1. When the family arrived at the hospital, Resident #1 was inverted. Her eyes were wide open and there were tubes coming out from all over. The hospital reported Resident #1 was bleeding internally, and he saw a tube draining blood protruding from her body. Resident #1 had bruises all over her and a large gash on her chest. It was bad. He explained Resident #1 had specific Advanced Directives; she did not want tubes or life support. RN D spoke with him that morning and admitted that the DNR copy was in her chart the day of the event. He concluded by saying it took one hour to revive Resident #1, only for her daughter to have to go in and unplug her. The facility's policy for Advance Directives (AD), SHCO20003.16 (reviewed [DATE]) revealed: Policy: The resident has the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advanced directive . Procedure: (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Provide information about ADs (Advance Directoves) to resident . 2. The resident or surrogate will be questioned at the time of admission about the existence of any AD written prior to admission . . 4. The attending physician shall record in the medical record pertinent information related to the formulation or implementation of the AD . . 5. The attending physician must document in the medical record the discussion with the resident or surrogate regarding choices and decisions of Advanced Directives. a. Upon executing any valid AD, the designated paperwork will be placed in the resident's medical record under the AD tab. b. When responding to a call for assistance, health care professionals and emergency personnel will honor the Advance Directive. (Photographic evidence obtained) Certified Nursing Assistant (CNA) F was interviewed on [DATE] at 9:14 a.m. She said if she were to find a resident unresponsive, she would notify a nurse immediately. A Code Blue would be called and the nurse would check the resident's code status. Everyone would come together with the crash cart and CPR would be performed, if appropriate. Resident code statuses were in the electronic medical record and the CNA Kardex (a sheet containing a summary of patient information). LPN G was interviewed on [DATE] at 9:30 a.m. She reported that on admission, a resident's code status was determined through a chart review. If the resident had no Advance Directives (AD), the admitting nurse obtained them and enters them into the chart the same day. The goldenrod copy (Florida DNR form) was scanned into the computer and the nurse entered the order into the electronic physician's orders. For a resident with a DNR order, the nurse must verify the goldenrod copy was present even though the physician's order and the resident's dashboard instructed DNR. In a second interview on [DATE] at 1055 a.m. , she stated now, once any new order or order change was entered into the EMR, the system asked for a second reviewer. Another nurse must review and sign off on the order before the doctor did. This was also required for discontinued orders. There was also a name alert system for similar or same last names. The admitting nurse entered the name alert onto the EMR dashboard. The Unit Manager completed chart checks the next morning for all new admissions and name alerts and new orders were checked. This was also checked every morning in the clinical meetings. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN E was interviewed on [DATE] at 9:36 a.m. She explained that prior to or on admission, the admitting nurse reviewed the record for Advanced Directives. If there were none in place, and no goldenrod DNR form, the resident was deemed a full code. The DNR form was scanned into the miscellaneous file in the electronic medical record. If a resident coded, the nurse checked the chart for the physician's order. The code status was on the dashboard in the electronic record. The facility completed Code Blue drills monthly on each of the three shifts. AD training was covered in the drills. Employee E was involved the day staff found Resident #1 unresponsive. A Code Blue was called, the chart was reviewed, and she looked in the electronic record, which contained a physician's order for full code. LPN E reported that she initiated CPR and continued until paramedics took over. There was confusion with the situation; the DNR had been misplaced for [Resident #1]. In a second interview on [DATE] at 11:00 a.m., LPN E explained the process for new orders, order changes and new admissions. She stated a second nurse must now verify every doctor's order. Also, for all new admissions, they were checked for similar names. The clinical team reviewed this and identified similarities, and the nurse entered the special instruction Name Alert on the EMR dashboard. LPN E pulled up two residents with the same last name in the EMR and showed an example of the NAME ALERT location on the dashboard. RN H was interviewed on [DATE] at 11:48 a.m. She stated on admission, nurses checked the hospital records for ADs. Sometimes the hospital did not send them, so the nurses asked the supervisor or Unit Manager (UM) to locate them. We can also ask the patient if they have a DNR and check the miscellaneous tab for any forms. The DNR should be there in the chart. If a resident came in and wanted to be a Full Code, she notified the social worker and the physician. All patients are Full Code until a DNR order is executed. Upon finding a resident unresponsive, the nurse checked the electronic medical record and verified the order, then went to the miscellaneous tab or hard chart to look for the goldenrod DNR form, if applicable. She added that this month she received training on ADs and how to enter them in the EMR. Also, if the resident had a name like that of another, a name alert went on the chart and in the EMR on the special bar in caps lock. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Administrator (and the Director of Clinical Services (DCS) and the Regional Clinical Director (RCD) on [DATE] at 2:08 p.m., the Administrator explained that on Sunday [DATE] at approximately 5:15 a.m., CNA K found Resident #1 unresponsive. CNA K alerted RN B, who checked for Resident #1's code status. They also found LPN C, the other nurse on the floor. He called 911 and announced the Code Blue overhead, then ran to assist with resuscitation efforts. At this time, LPN E was coming in for her shift and went to assist with CPR. EMTs arrived and took over at 5:18 a.m. Resident #1 left with the EMTs. When RN D contacted the family, he was advised that Resident #1 had a DNR order. RN D started to investigate and looked at Resident #1's chart. The electronic medical record reflected that she was a Full Code, but a signed, dated goldenrod DNR form was scanned into the miscellaneous section of the record. The responding nurses followed the Full Code order, but it had been entered into the record incorrectly. The night before, a resident with a very similar name was discharging home. LPN A inadvertently discharged Resident #1 from the electronic medical record instead of the discharging resident, but caught her mistake immediately and entered her back into the system. Unfortunately, she mis-transcribed the Full Code order; she clicked on the wrong box. LPN A thought Resident #1 was a Full Code and thought she was entering the correct status. The DCS added that LPN A had been assigned to this resident before and the DCS didn't know why she entered the order incorrectly. She did immediately realize she had discharged the wrong resident from the system. A root cause analysis was completed and corrective and preventative measures were identified. Audits were completed for 100% of residents (112) charts for code status, which was verified with the physician's orders, and name similarities. The facility implemented a process and educated nurses this same day on sound alike names (the Name Alert on the EMR dashboard and alert stickers on binders). Education about transcribing orders was initiated and 100% of nurses had been trained in all of the above with return demonstration. On admission, a two-person check was done now. This would also be required for re-implementation of physician's orders and order changes. Newly hired nurses would be trained in the same with return demonstration. All policies and procedures were reviewed and remained appropriate. LPN A received verbal 1:1 (one-to-one) education immediately and was very remorseful. The Administrator advised that LPN A was permitted to return to work once the investigation was completed. LPN A received additional training (that had occurred on [DATE], which she produced). An ad hoc QAPI meeting was held on [DATE]; the entire team came in on Sunday ([DATE]) to ensure that everything was in place. Audits were being conducted five times a week for three months, Mon - Friday, and were reviewed during clinical meetings every morning. The order listing reports were being reviewed daily by the staff development coordinator (SDC), the DON and the Administrator. Any order with ADs and all new admissions were being reviewed daily. Stand-up and stand-down daily meetings were also looking at order changes or new orders during the shift. Five sets of residents with similar first or last names were identified during the name audit. There had been one newly hired nurse who was trained in the process on [DATE]. In an interview with RN J on [DATE] at 3:30 p.m., he explained that all DNR documentation would be entered by nursing staff into the EMR to be easily accessed in the event of a resident code. This would facilitate identifying which residents had DNR orders when a code occurred. RN J then advised that each resident's code status and documentation would be double checked by two nurses to ensure accuracy. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN/Unit Manager (UM) I was interviewed on [DATE] at 11:20 a.m. She explained that recent training had been provided to nurses on Advance Directives. The process was that on admission, she called the physician and reviewed all medication and the code status. In the morning, the entire clinical team reviewed each admission. This was documented. The team reviewed the residents' code status for accuracy. The more eyes the better. We ensure all the batch (physician's) orders are entered in the EMR and any specialty orders are in place. Also, on admission a name alert is done. For instance, we currently have two residents with the same last name on one unit. We put the NAME ALERT in the record under the special instructions tab. This is also double checked in clinical meetings. On occasion, a float nurse comes in, so the name alert is very important. We all received training on this. LPN/UM I conducted huddle meetings with the staff when such pertinent similar information needed to be reviewed. Any accidental discharge and readmission would be treated as a new admission; you had to redo all of it. It is a lot of work but it must be done properly. Now two nurses must sign off on physicians' orders. Also, any verbal orders must receive two nurses signatures. If a family comes in and wants to change an order to a DNR, the form gets printed and the family must sign it. The verbal physician's order is good for 24 hours. The form is faxed to the doctor for a signature and date and the order is entered in the EMR. Once the executed copy is received, the DNR goes into the chart. It is always scanned into the miscellaneous tab. The hard copy goes into the hard chart. At daily stand-up and stand-down meetings, the Administrator asks about ADs, DNRs and order changes for code status. When EMS (emergency medical services) comes in, you better have that ready for them. LPN/UM I concluded by reporting that she was involved in assisting with the daily audits for new admissions and order changes. RN B was interviewed on [DATE] at 1:55 p.m. He stated he worked the overnight shift on weekends and was assigned to Resident #1 the night of the event. It was a quiet night. He was rounding and ready to give medications when a CNA notified him that Resident #1 was unresponsive. Per protocol, he went and checked the electronic record for the code status. Resident #1 had a physician's order for Full Code status; this order was on the electronic record's dashboard and medication screen. Since Resident #1 was documented as a Full Code at that time, he went by the order and started CPR. RN B performed CPR for a bunch of circuits; it was exhausting. LPN C and another nurse came in to help, then paramedics arrived and took over. RN B had the laptop computer with him and relayed the Full Code order to paramedics, who then transported Resident #1 to the hospital. RN B resumed his normal duties. When he came back to work the next day, he was advised that Resident #1 had a DNR order. RN B said, No, she was a Full Code. As a result, he received training on code status and checking orders if they were taken off and put back in. He did a return demonstration. Two nurses must verify orders. RN B was trained on name alerts. They now went in all capital letters in the chart if there were residents with alike names. When there was a DNR form, he put it right in the front of the paper (hard) chart. He was not sure who scanned the forms into the electronic medical records but he checked the EMR. RN D was interviewed on [DATE] at 2:13 p.m. He stated he came in after the event on [DATE] and was told that Resident #1 had coded. CPR was provided and she was sent to the hospital. He thought LPN C phoned the resident's family but nobody answered. RN D went to pass breakfast trays, then attempted to call the family again. He spoke with one of Resident #1's relatives, who asked why Resident #1 was provided CPR and sent to the hospital; Resident #1 had a DNR order. RN B informed him he would investigate that and call back. RN D then called the DON and reported the conversation. She came to the facility and she and RN D found the DNR form in Resident #1's scanned electronic documents. The DON spoke with LPN A, took her statement, and sent her home pending investigation. (continued on next page)

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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** 30969 Based on a review of resident records, the facility's policy and procedure for CPR; Cardiopulmonary Resuscitation, facility reports, and interviews with staff, the facility failed to act in accordance with the resident's Advance Directives and her Do Not Resuscitate (DNR) status (the desire have CPR withheld in the event her heart or breathing stopped) by providing CPR upon finding her unresponsive with no respirations. This affected one (Resident #1) of nine residents reviewed for Advance Directives. The facility's failure to review and honor Resident #1's DNR deprived her of a natural death and likely caused unnecessary pain and bodily damage. Resident #1 expired in the hospital after prolonged life-sustaining efforts had been made and after family discontinued her from life support. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 1:59 p.m. on [DATE]. On [DATE] at 3:06 p.m., Immediate Jeopardy began. On [DATE] at 2:50 p.m., the Administrator was notified of the IJ determination, IJ Templates were provided, and Immediate Jeopardy was removed, effective [DATE]. The facility remained out of compliance, and after verification of the removal of immediate jeopardy, the scope and severity were reduced to D, no actual harm, with a potential for no more than minimal harm, due to the facility's nursing staff having provided cardiopulmonary resuscitation (CPR) to a resident with a Do Not Resuscitate (DNR) order. The findings include: Cross Reference F578 A closed record review for Resident #1 found she was admitted from the hospital on [DATE]. Her diagnoses included, but were not limited to, toxic encephalopathy (brain dysfunction caused by toxic exposure), other neurological conditions, atrial fibrillation (irregular heartbeat that often causes poor blood flow), hypertension, diabetes mellitus, dementia, malnutrition, and chronic obstructive pulmonary disease/asthma. Resident #1 had a Modification of a Discharge/Return Anticipated Minimum Data Set (MDS) assessment with an assessment reference date of [DATE], which revealed admission from a short-term acute care hospital on [DATE]. Resident #1 had an unplanned discharge on [DATE] back to an acute hospital. She was assessed as being independent with daily decision making and required supervision to partial assistance with activities of daily living. Active discharge planning was occurring for Resident #1 to return to the community. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105735	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was care planned on [DATE] for short-term care and discharge to home, with the goal to verbalize required assistance post-discharge and the services required to meet her needs before discharge. Interventions included: . Resident has been informed of their right to participate in establishing the expected goals and outcomes of care . to be informed, in advance, of changes to the plan of care . Resident has been informed of their right to request, refuse and/or discontinue treatment . Short Term Care. (Photographic evidence obtained) Resident #1 was care planned on [DATE] for Advance Directives in place, however, no code status was noted. A revision to the care plan, dated [DATE], two weeks after her discharge, noted she was a Full Code. The goal was for Resident #1's Advance Directives to be honored by staff. Interventions contradicted the focus area and noted she had a DNR. (Photographic evidence obtained) The electronic medical record (EMR) for Resident #1 contained a Florida DNR form which was signed by the resident and her physician on [DATE]. There was a corresponding physician's order for DNR dated [DATE]; however, this order was discontinued on [DATE] at 3:06 p.m. by LPN A. The reason for discontinuing the DNR order was noted as DC (discharge) home. (Photographic evidence obtained) On [DATE] at 6:38 p.m., LPN A entered an order for Full Code. (Photographic evidence obtained) Resident #1 was last seen by the Advanced Practice Registered Nurse (APRN) on [DATE] for discharge planning. The APRN noted Resident #1 reported no concerns and was medically stable at this time. (Photographic evidence obtained) Nursing progress notes reflected on [DATE], that Resident #1 was alert and oriented x3 (to person, place, and name). On [DATE], she was noted to be disoriented x3 and alert but lethargic. A note dated [DATE] at 5:10 a.m. by Registered Nurse (RN) B, reported that a certified nursing assistant (CNA) came to him to report that Resident #1 was not breathing. RN B checked for a pulse but it was absent. The nurse assigned to the other medication cart called 911, called a Code Blue, and got the crash cart. A subsequent note authored by RN B on [DATE] at 5:18 a.m., reported that emergency medical technicians (EMTs) arrived with the fire department, accessed the resident, and started [chest] compressions. At 5:42 a. m., EMTs left the facility with Resident #1. A review of a facility report revealed that on [DATE] at approximately 5:15 a.m., Resident #1 was found unresponsive by CNA K. She notified RN B, who observed the resident without a pulse or respirations and resuscitation was performed per the active physician's order by RN B, Licensed Practical Nurse (LPN) C and LPN E. It was discovered by RN D through conversation with a family member and a review of the Florida goldenrod form, that Resident #1 had a Do Not Resuscitate status. Resident #1 expired at the hospital at 8:33 a.m. A staff member (LPN A) had inadvertently discharged Resident #1 on [DATE]. Upon immediately realizing her mistake, she reinstated all discharged orders but inadvertently reinstated a Full Code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's analysis of the incident noted its investigation verified unintentional neglect. Resident #1 had been admitted to the facility on [DATE]. On [DATE], CNA K entered Resident #1's room to provide morning care to Resident #1's roommate. When she went to see Resident #1, the resident was unresponsive. CNA K immediately notified RN B, who assessed Resident #1 and found she had no pulse or respirations. RN B checked Resident #1's code status in the electronic medical record and found orders for a Full Code. He then requested that CNA K retrieve the crash cart and notify LPN C to call a Code Blue overhead. RN B initiated CPR per the active orders in the EMR since Resident #1 was unresponsive and without signs of rigor or advanced death. LPN C called 911, then assisted LPN E and RN B until EMTs arrived and took over resuscitation. Resident #1 was taken to the hospital at 5:18 a.m. with the [NAME] Chest Compression System (mechanical chest compression device) in process. At 9:00 a.m. the weekend supervisor, RN D, was attempting to contact Resident #1's primary contact, since the prior phone call made by LPN C had not been returned. Another family member answered the phone and reported that Resident #1 had a DNR code status and that the family had given these documents to the facility upon her admission. RN B reviewed the medical record and confirmed the presence of the DNR. While reviewing the medical record, the Director of Nursing (DON) and RN D identified that Resident #1 had been mistakenly discharged from the EMR on [DATE] by LPN A. She had inadvertently discharged Resident #1 instead of a different resident with a similar name. LPN A caught her mistake immediately on [DATE] and re-entered Resident #1's physician's orders into the EMR. While doing so, she transcribed the code status as Full Code when it should have been Do Not Resuscitate. Psychological harm to the resident's family was identified during an interview with Resident #1's family member on [DATE] at 12:15 p.m. The family member stated Resident #1 was admitted to the facility with an active DNR order. For some reason on the day of the event, nobody saw it so it was not honored. It was a mistake and the facility apologized. Between facility and hospital staff, they spent an hour resuscitating Resident #1. When the family arrived at the hospital, Resident #1 was inverted. Her eyes were wide open and there were tubes coming out from all over. The hospital reported Resident #1 was bleeding internally, and he saw a tube draining blood protruding from her body. Resident #1 had bruises all over her and a large gash on her chest. It was bad. He explained Resident #1 had specific Advanced Directives; she did not want tubes or life support. RN D spoke with him that morning and admitted that the DNR copy was in her chart the day of the event. He concluded by saying it took one hour to revive Resident #1, only for her daughter to have to go in and unplug her. The facility's policy for CPR; Cardiopulmonary Resuscitation, SHCRC10001.01 (revised [DATE]), read: Policy: The center shall provide basic life support, including CPR, when a resident requires such emergency care, prior to the arrival of of emergency medical services, subject to a physician's order and resident choice indicated in the resident's advanced directives. CPR will be initiated unless: - A valid DNR order is in place . Procedure: 1. In the event of cardiac or respiratory arrest, identify code status. If no DNR order exists, or there are no obvious signs of irreversible death, begin CPR . (Photographic evidence obtained) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA F was interviewed on [DATE] at 9:14 a.m. She said if she were to find a resident unresponsive, she would notify a nurse immediately. A Code Blue status would be called and the nurse would check the code status. Everyone would come together with the crash cart and CPR would be performed, if appropriate. Resident code statuses were in the electronic medical record and the CNA Kardex (a sheet containing a summary of patient information). LPN G was interviewed on [DATE] at 9:30 a.m. She reported that on admission, the resident's code status was determined through a chart review. If the resident had no Advanced Directives (AD), the admitting nurse obtained one and entered it into the chart the same day. The goldenrod copy (Florida DNR form) was scanned into the computer and the nurse entered the order into the electronic physician's orders. For a resident with a DNR order, the nurse must verify the goldenrod copy was present even though the physician's order and the resident's dashboard instructed DNR. In a second interview on [DATE] at 1055 a. m. she stated that now, once any new order or order change was entered into the EMR, the system asked for a second reviewer. Another nurse must review and sign off on the order before the doctor did. This was also required for discontinued orders. There was also a name alert system for similar or same last names. The admitting nurse entered the name alert onto the EMR dashboard. The unit manager completed chart checks the next morning for all new admissions and name alerts and new orders were checked. This was also checked every morning in the clinical meetings. LPN E was interviewed on [DATE] at 9:36 a.m. She explained that prior to or upon admission, the admitting nurse reviewed the record for Advanced Directives. If there were none in place, and there was no goldenrod DNR form, the resident was deemed a Full Code. The DNR form was scanned into the miscellaneous file in the electronic medical record. If a resident coded, the nurse checked the chart for the physician's order. The code status was on the dashboard in the electronic record. The facility completed Code Blue drills monthly on each of the three shifts. AD training was covered in the drills. LPN E was involved the day staff found Resident #1 unresponsive. A Code Blue was called, the chart was reviewed, and she looked in the electronic record, which contained a physician's order for Full Code. LPN E reported that she initiated CPR and continued until paramedics took over. There was confusion with the situation; the DNR had been misplaced for [Resident #1]. In a second interview on [DATE] at 11:00 a.m., LPN E explained the process for new orders, order changes and new admissions. She stated a second nurse must verify every doctor's order. Also, all new admissions were checked for similar names. The clinical team reviewed this and identified similarities, and the nurse entered the special instruction Name Alert on the EMR dashboard. LPN E pulled up two residents with the same last name in the EMR and showed the NAME ALERT location on the dashboard. RN H was interviewed on [DATE] at 11:48 a.m. She stated on admission, nurses checked the hospital records for ADs. Sometimes the hospital did not send them, so the nurses asked the supervisor or Unit Manager (UM) to locate them. We can also ask the patient if they have a DNR and check the miscellaneous tab for any forms. The DNR should be there in the chart. If a resident came in and wanted to be a Full Code, she notified the social worker and the physician. All patients are Full Code until a DNR order is executed. Upon finding a resident unresponsive, the nurse checked the electronic medical record and verified the order, then went to the miscellaneous tab or hard chart to look for the goldenrod DNR form, if applicable. She added that this month she received training on ADs and how to enter them in the EMR. Also, if the resident had a name like that of another, a name alert went on the chart and in the EMR on the special bar in caps lock. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Administrator (and the Director of Clinical Services (DCS) and the Regional Clinical Director (RCD) on [DATE] at 2:08 p.m., the Administrator explained that on Sunday [DATE] at approximately 5:15 a.m., CNA K found Resident #1 unresponsive. CNA K alerted RN B, who checked for Resident #1's code status. They also found LPN C, the other nurse on the floor. He called 911 and announced the Code Blue overhead, then ran to assist with resuscitation efforts. At this time, LPN E was coming in for her shift and went to assist with CPR. EMTs arrived and took over at 5:18 a.m. Resident #1 left with the EMTs. When RN D contacted the family, he was advised that Resident #1 had a DNR order. RN D started to investigate and looked at Resident #1's chart. The electronic medical record reflected that she was a Full Code, but a signed, dated goldenrod DNR form was scanned into the miscellaneous section of the record. The responding nurses followed the Full Code order, but it had been entered into the record incorrectly. The night before, a resident with a very similar name was discharging home. LPN A inadvertently discharged Resident #1 from the electronic medical record instead of the discharging resident, but caught her mistake immediately and entered her back into the system. Unfortunately, she mis-transcribed the Full Code order; she clicked on the wrong box. LPN A thought Resident #1 was a Full Code and thought she was entering the correct status. The DCS added that LPN A had been assigned to this resident before and the DCS didn't know why she entered the order incorrectly. She did immediately realize she had discharged the wrong resident from the system. A root cause analysis was completed and corrective and preventative measures were identified. Audits were completed for 100% of residents (112) charts for code status, which was verified with the physician's orders, and name similarities. The facility implemented a process and educated nurses this same day on sound alike names (the Name Alert on the EMR dashboard and alert stickers on binders). Education about transcribing orders was initiated and 100% of nurses had been trained in all of the above with return demonstration. On admission, a two-person check was done now. This would also be required for re-implementation of physician's orders and order changes. Newly hired nurses would be trained in the same with return demonstration. All policies and procedures were reviewed and remained appropriate. LPN A received verbal 1:1 (one-to-one) education immediately and was very remorseful. The Administrator advised that LPN A was permitted to return to work once the investigation was completed. LPN A received additional training (that had occurred on [DATE], which she produced). An ad hoc QAPI meeting was held on [DATE]; the entire team came in on Sunday ([DATE]) to ensure that everything was in place. Audits were being conducted five times a week for three months, Mon - Friday, and were reviewed during clinical meetings every morning. The order listing reports were being reviewed daily by the staff development coordinator (SDC), the DON and the Administrator. Any order with ADs and all new admissions were being reviewed daily. Stand-up and stand-down daily meetings were also looking at order changes or new orders during the shift. Five sets of residents with similar first or last names were identified during the name audit. There had been one newly hired nurse who was trained in the process on [DATE]. In an interview with RN J on [DATE] at 3:30 p.m., he explained that all DNR documentation would be entered by nursing staff into the EMR to be easily accessed in the event of a resident code. This would facilitate identifying which residents had DNR orders when a code occurred. RN J then advised that each resident's code status and documentation would be double checked by two nurses to ensure accuracy. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN/Unit Manager (UM) I was interviewed on [DATE] at 11:20 a.m. She explained that recent training had been provided to nurses on Advance Directives. The process was that on admission, she called the physician and reviewed all medication and the code status. In the morning, the entire clinical team reviewed each admission. This was documented. The team reviewed the residents' code status for accuracy. The more eyes the better. We ensure all the batch (physician's) orders are entered in the EMR and any specialty orders are in place. Also, on admission a name alert is done. For instance, we currently have two residents with the same last name on one unit. We put the NAME ALERT in the record under the special instructions tab. This is also double checked in clinical meetings. On occasion, a float nurse comes in, so the name alert is very important. We all received training on this. LPN/UM I conducted huddle meetings with the staff when such pertinent similar information needed to be reviewed. Any accidental discharge and readmission would be treated as a new admission; you had to redo all of it. It is a lot of work but it must be done properly. Now two nurses must sign off on physicians' orders. Also, any verbal orders must receive two nurses signatures. If a family comes in and wants to change an order to a DNR, the form gets printed and the family must sign it. The verbal physician's order is good for 24 hours. The form is faxed to the doctor for a signature and date and the order is entered in the EMR. Once the executed copy is received, the DNR goes into the chart. It is always scanned into the miscellaneous tab. The hard copy goes into the hard chart. At daily stand-up and stand-down meetings, the Administrator asks about ADs, DNRs and order changes for code status. When EMS (emergency medical services) comes in, you better have that ready for them. LPN/UM I concluded by reporting that she was involved in assisting with the daily audits for new admissions and order changes. RN B was interviewed on [DATE] at 1:55 p.m. He stated he worked the overnight shift on weekends and was assigned to Resident #1 the night of the event. It was a quiet night. He was rounding and ready to give medications when a CNA notified him that Resident #1 was unresponsive. Per protocol, he went and checked the electronic record for the code status. Resident #1 had a physician's order for Full Code status; this order was on the electronic record's dashboard and medication screen. Since Resident #1 was documented as a Full Code at that time, he went by the order and started CPR. RN B performed CPR for a bunch of circuits; it was exhausting. LPN C and another nurse came in to help, then paramedics arrived and took over. RN B had the laptop computer with him and relayed the Full Code order to paramedics, who then transported Resident #1 to the hospital. RN B resumed his normal duties. When he came back to work the next day, he was advised that Resident #1 had a DNR order. RN B said, No, she was a Full Code. As a result, he received training on code status and checking orders if they were taken off and put back in. He did a return demonstration. Two nurses must verify orders. RN B was trained on name alerts. They now went in all capital letters in the chart if there were residents with alike names. When there was a DNR form, he put it right in the front of the paper (hard) chart. He was not sure who scanned the forms into the electronic medical records but he checked the EMR. RN D was interviewed on [DATE] at 2:13 p.m. He stated he came in after the event on [DATE] and was told that Resident #1 had coded. CPR was provided and she was sent to the hospital. He thought LPN C phoned the resident's family but nobody answered. RN D went to pass breakfast trays, then attempted to call the family again. He spoke with one of Resident #1's relatives, who asked why Resident #1 was provided CPR and sent to the hospital; Resident #1 had a DNR order. RN B informed him he would investigate that and call back. RN D then called the DON and reported the conversation. She came to the facility and she and RN D found the DNR form in Resident #1's scanned electronic documents. The DON spoke with LPN A, took her statement, and sent her home pending investigation. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the partial extended survey, the facility provided their immediate jeopardy removal plan, and these immediate actions were verified as having been completed by the surveyor as follows: An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was conducted with the Interdisciplinary Team and Medical Director and a Performance Improvement Plan (PIP) was developed and initiated on [DATE] to provide immediate correction and attain/maintain regulatory compliance. The Topic/Opportunity identified was: Accuracy of transcription of orders and Advanced Directives: Nurse inadvertently discontinued orders including AD, reinstated with transcription error. Actions included: 1. Ad hoc QAPI meeting held [DATE]. 2. MD (Medical Director) and resident representative notified of AD variance on [DATE]. 3. A statement was obtained from the licensed nurse who transcribed the DNR/Full code order- Completed [DATE]. 4. Facility management identified a Root Cause for the transcription error- Completed [DATE]. 5. 1:1 education with licensed nurse responsible for the error (LPN A)- Completed [DATE]. 6. A complete facility audit was conducted of all resident ADs for accuracy- Completed [DATE] for all 111 residents. 7. A facility audit of sound alike names was conducted and a profile tab was made in the EMR for residents with like names- Completed [DATE] for all 111 residents. 8. Alike resident names were documented as NAME ALERTs in the Care Profile tab in the residents' EMRs- Completed [DATE] for 10 residents who had similar names. Ongoing. 9. All licensed nurses were educated about physician order transcription from discontinued orders in the EMR. Written post-test- Commenced [DATE], completed [DATE] for all 33 nurses including LPN A who was re-educated and provided the post-test after return from suspension [DATE]. One new hire was educated and tested on [DATE]. All nurses were educated about sound alike names and documenting the name alert in the care profile tab in the EMR. Written post-test completed- Commenced [DATE], completed [DATE] for all 33 nurses. LPN A who was included in the initial education on [DATE] was re-educated and provided the post test on return from suspension, [DATE]. One new hire was educated and tested [DATE]. Ongoing. 10. New hires will be educated during orientation on medication order transcription from discontinued orders in EMR, and on identifying sound alike names and documenting name alerts- Completed [DATE] for one newly hired nurse. Ongoing. 11. DNR orders and Full Code orders review extablished to ensure accuracy of ADs in daily clinical meetings- Initiated [DATE]. Ongoing. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12. Sound alike names review initiated in clinical meetings daily to ensure name alerts were in the profile tab of the electronic medical record. Initiated [DATE]. Ongoing. 13. Audits were initiated five times per week for three months during clinicals when resident orders are being reviewed to ensure DNR and Full Code orders are accurate- Commenced [DATE], with subsequent audits completed [DATE], 6, 7, 8, 11, 12, 23, 14, 25, 18 and 19, 2024. Ongoing.