

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Westminster Towers		STREET ADDRESS, CITY, STATE, ZIP CODE 70 West Lucerne Circle Orlando, FL 32801	

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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646</p> <p>Based on interview, and record review, licensed nurses failed to follow the facility's policy and procedure for Cardiopulmonary Resuscitation (CPR) related to verification of code status in an emergency for 1 of 13 residents reviewed for advance directives, (#1).</p> <p>On [DATE] at approximately 7:00 PM, resident #1 was observed unresponsive in her bed. Registered Nurse (RN) A took her vitals and notified RN C resident #1 had passed away. RN A failed to verify resident #1's code status and failed to provide CPR per her wishes. Emergency Medical Services was never called. The facility failed to honor the resident's wish to be resuscitated and the physician order for Full Code status.</p> <p>The facility's failure to ensure staff followed procedures related to honoring an advance directive to provide lifesaving measures including CPR for a resident on hospice care contributed to resident #1's death. This action placed all residents who received hospice care at risk of not having their wishes honored. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed on [DATE]. The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings:</p> <p>Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including unspecified sequelae of cerebral infarction (stroke), adult failure to thrive, moderate protein-calorie malnutrition, major depressive disorder and atherosclerotic heart disease (hardening of the blood vessels).</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status score of ,d+[DATE] which indicated she had severe cognitive impairment. The document revealed she had a prognosis that might result in a life expectancy of less than six months and she received hospice care.</p> <p>Review of the electronic medical record (EMR) revealed a social services progress note dated [DATE] which indicated the Social Services Director (SSD) spoke with resident #1 and her husband regarding her code status. The resident and her husband rescinded her previous Do Not Resuscitate (DNR) order to become a full code. Resident #1's husband stated to the SSD that was what his wife wanted.</p> <p>(continued on next page)</p>

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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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1 had a care plan for advanced directives initiated on [DATE]. The focus indicated the advanced directives had been reviewed and included, FULL CODE. The goal was the resident's wishes would be honored through the next review date. Interventions included for staff to make the resident's wishes known through the care continuum.</p> <p>Resident #1's EMR contained a physician order dated [DATE] which read, Full Code. The words Full Code were displayed under the Advance Directive section on the Medication Administration Record for February 2025.</p> <p>A care plan meeting was held on [DATE] with resident #1's husband. Code status was reviewed and no changes were made to her advanced directives. A progress note dated for [DATE] read, She remains a Full Code status currently.</p> <p>A Health Status Note dated [DATE] at 4:02 PM, indicated resident #1 had an oxygen saturation rate of 80% and an order was obtained for 2 liters of oxygen via nasal cannula. Hospice was contacted and orders for Morphine and Ativan were received. No other notes were recorded until [DATE] at 9:11 PM which indicated resident #1 was pronounced deceased at approximately 8:15 PM. The note indicated family and hospice were present at that time after being contacted by the facility.</p> <p>In a phone interview on [DATE] at 1:22 PM, RN A verified she was assigned to resident #1 on the 3:,d+[DATE]:00 PM shift on [DATE]. She recalled the nurse from the previous shift reported resident #1 was not doing well and hospice had been notified. RN A stated resident #1's husband approached her earlier on the 3:,d+[DATE]:00 PM shift and requested she contact hospice again for someone to come and evaluate her for crisis care. She explained the resident's husband expressed he wanted her to be comfortable and not suffer. RN A recalled she entered resident #1's room later at approximately 7:00 PM and observed the resident was unresponsive and did not appear to be breathing. She stated she checked resident #1's vital signs and did not find a pulse or respirations. RN A explained she asked RN C to assist and they provided postmortem care. RN A verified she did not initiate CPR. She explained resident #1 received hospice services and she had always known resident #1 to be a DNR code status. RN A acknowledged she was not aware resident #1 had Full Code status. She stated the facility procedure was to look in the resident's chart to verify the resident's code status. RN A acknowledged she would have realized the resident was a Full Code and not a DNR if she had looked in the chart.</p> <p>In a phone interview on [DATE] at 3:24 PM, RN C verified she was working on the 3:,d+[DATE]:00 PM shift on [DATE] but was not assigned to resident #1. RN C recalled she was in a room with another resident when RN A approached her and informed her resident #1 had expired. RN C stated she went to resident #1's room afterwards and asked if everything had been done and was told it had. She reported she assisted RN A in providing postmortem care. RN C explained she did not hear a Code Blue announcement and thought RN A had verified resident #1's code status prior to alerting her to resident #1's death. RN C stated procedure was to call a Code Blue if a resident was found unresponsive and staff would come with the crash cart and the resident's chart to verify code status prior to initiating CPR.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a phone interview on [DATE] at 12:54 PM, RN Supervisor B confirmed she was working the 3:, d+[DATE]:00 PM shift on [DATE]. She recalled being on a different floor orienting a new resident and their answering questions when RN A called to let her know resident #1 had expired. RN Supervisor B stated she went to the other floor and confirmed resident #1 had no vital signs. She proceeded to call the hospice and inform them of the resident's death. RN Supervisor B explained she assumed resident #1 was a DNR because she was under hospice care. She stated she was not aware a resident could be Full Code under hospice care. RN Supervisor B explained that RN A did not inform her resident #1 was a Full Code. She acknowledged she did not verify the resident's code status as she thought RN A had already done so. RN Supervisor B expressed she was not aware there was an error until the Director of Nursing contacted her a few days later on [DATE].</p> <p>On [DATE] at 2:14 PM, resident #1's husband confirmed she desired to have resuscitative measures and be a Full Code. He explained his wife had been very active in the community prior to her stroke in [DATE] but had not been the same since. He recalled signing up for hospice care a couple of months ago but was not sure what could be done for her as she refused a lot of care. He reported during the last week of her life, he would ask how she was doing, and she would reply, I am still here, if she said anything at all. Resident #1's husband recalled she was not very responsive during his visit earlier in the day on [DATE]. He left to go to dinner and was later notified he needed to return to the health center because she had passed away. Resident #1's husband again confirmed she was a Full Code and explained he did not think CPR would benefit her, but it was her wish to have it performed. He expressed he was not going to argue with her.</p> <p>On [DATE] at 2:41 PM, the Administrator stated he and the Director of Nursing (DON) were notified of resident #1's death on [DATE] but were not notified she had full code orders. He recalled the 3rd Floor Assistant Director of Nursing notified him and the DON of discrepancies in the documentation regarding resident #1's death. The documentation was reviewed and did not appear to support the events of that evening. The Administrator reported they could not reach RN A until 1:52 PM on [DATE] to get details of what had occurred. He stated from the interviews with RN A, RN C and RN Supervisor B, they determined a Code Blue was not called and resident #1 was not provided CPR. The Administrator acknowledged RN A failed to verify resident #1's code status per facility policy and therefore did not initiate CPR. He reported resident #1 was later pronounced deceased by the hospice nurse and her body was removed by the funeral home.</p> <p>The Facility's policy and procedure for CPR dated [DATE] read, If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and in accordance with the resident's advance directives.</p> <p>Review of the immediate corrective measures implemented by the facility revealed the following, which were verified by the survey team:</p> <p>*On [DATE] Administrator and DON were made aware of discrepancies in resident #1's chart regarding her passing, and initiated an investigation.</p> <p>*On [DATE] the facility completed an in-house audit for code status of all residents. No additional issues were identified.</p> <p>(continued on next page)</p>		

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