STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on interviews, and record review, the facility failed to protect the resident's right to be free from neglect by failing to honor the resident's wishes for life saving measures, by failing to follow physician's order for Full Code and failing to initiate Cardiopulmonary Resuscitation (CPR) for 1 of 6 residents reviewed for Advanced Directives, of a total sample of 8 residents, (#2). On [DATE] at approximately 10:05 PM, resident #2 was found not breathing by Certified Nursing Assistant (CNA) D. The CNA notified Licensed Practical Nurse (LPN) C who evaluated the resident with no vital signs. LPN C did not check the resident's code status nor provide CPR but instead informed the Weekend Supervisor Registered Nurse (RN) E of the situation at approximately 10:08 PM. RN E found resident #2 without any vital signs and failed to initiate CPR although he knew the resident had a physician order for Full Code. Both nurses failed to provide CPR, failed to call a code overhead for additional support, failed to call 911 and failed to notify the Assistant Director of Nurses (ADON) that they failed to provide CPR for a resident who was a full code. The facility's failure to provide CPR per the resident's Advanced Directives, care plan and physician's orders, resulted in Immediate Jeopardy beginning on [DATE]. On [DATE] there were 84 residents with full code orders in the facility. The Immediate Jeopardy was removed on [DATE] and the scope and severity of the deficiency was decreased to D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings: Cross reference F678 Review of the Facility Assessment updated [DATE] read, Services and Care We Offer Based on our Resident's Needs Provide person-centered/directed care .Record and discuss treatment and care preferences .Prevent abuse and neglect .Offer and assist resident and family caregivers [or other proxy as appropriate] to be involved in person-centered care planning and advance care planning .Resident rights and facility responsibilities-ensure that staff members are educated on the rights of the resident and responsibilities to properly care for its residents . (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated Abuse/Neglect policy read, Neglect: Harming the person in your care; either physically, mentally, or emotionally by failing to provide needed care .Passive Neglect: Unintentionally harming a person physically, mentally, or emotionally by failing to provide needed care. Caregiver may not know how to properly care for the person or may not understand the person's needs . Review of the medical record revealed resident #2, an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital with diagnoses of dementia, psychotic disturbance, cerebrovascular disease (stroke), sepsis, influenza A with pneumonia, anemia, atrial fibrillation (irregular heartbeat), chronic kidney disease, muscle weakness, dysphagia (difficulty swallowing) and adult failure to thrive. Review of resident 2's medical record revealed a physician's order dated [DATE] for Full Code Status. Review of resident #2's Annual Minimum Data Set, dated dated dated [DATE] revealed he had a Brief Interview of Mental Status score of 1 out of 15 which indicated he was severely cognitively impaired. He required partial to moderate assistance for toileting, bathing, and upper body dressing and maximum assistance for personal hygiene and mobility. Review of the resident's care plan for Advanced Directives dated [DATE] read, resident has the following Advanced Directives in place: DPOA [Designated Power of Attorney]. He is a full code status and goal for Advance Directives to be honored as written. Resident Progress Notes dated [DATE] by LPN A read, Resident returned to facility at approximately 7:49 PM, on stretcher Resident is FULL CODE .confused, non-verbal and bed bound .on hospice care . Review of resident Progress Notes dated [DATE] by the Social Services Assistant revealed, readmitted to facility from hospital stay. He's currently on .hospice services .continues as a full code status . Review of resident Progress Notes dated [DATE] at 2:06 PM, by Advanced Practice Registered Nurse (APRN) B read, CODE STATUS: Full Code .hospice .History of Present Illness: This is a long term patient . Pt [patient] found to be septic secondary to influenza A & LLL [left lower lobe] pna [pneumonia]. He was treated with Tamiflu & IV [intravenous] abx [antibiotics] .hospitalization complicated by afib [irregular heartbeat] Once stabilized pt [patient] transferred back .under the care of .hospice. The note indicated resident #2's son was at his bedside that day, the plan was for supportive care and he was a Full Code. Review of the resident Progress Notes dated [DATE] at 10:40 PM, by LPN C revealed at 10:05 PM the CNA called and let her know she thought resident #2 had died . The LPN documented she, Went to room and [found the resident] .died . Shift supervisor called right away at 10:08. PCP [primary care provider] made aware at 10:15 PM. Son called at 10:20 PM. Hospice also called. At this time, body still in bed waiting for final decision by Family and Hospice. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Resident Progress Notes dated [DATE] at 11:16 PM, read, Summoned to resident room. Resident has ceased to breathe. HR [heartrate] 0. Resident pronounced dead at 10:05 PM. On call [Supervisor] .made aware as well as ADON and .Hospice. Family notified of resident passing and [asked to] verify funeral home .Arrangements made for pick up at 12 AM. On [DATE] at 4:06 PM, an interview was conducted with the facility South Wing Unit Manager (UM), the Director of Nursing (DON), and the ADON who was the Risk Manager. When asked regarding resident #2 having orders in place for Full Code resuscitation but no documentation in the medical record to support he received CPR on [DATE] when he was found by staff with no vital signs, they acknowledged they were unaware of the concerns until the time of the survey. The UM said she did talk with hospice nurse RN F and the hospice Social Worker (SW) as well about the resident code status and was aware they had been working with the son in regards to obtaining DNR orders however he remained a Full Code until that physician order was obtained. The ADON, DON and the UM verified that residents must remain Full Code until they had DNR orders in place. They explained if a resident was found by the CNA that they preferred the CNA to get the nurse and then the nurse would start CPR, and the CNA could help to call the code/overhead page and 911. The DON stated, if no DNR, the staff need to initiate CPR. The UM verified she did have abuse/neglect training in the last three months and understood the definition of neglect was not providing the goods and services needed for a resident's care. On [DATE] at 5:03 PM, a telephone interview was conducted with resident #2's son who verified he was the Power of Attorney (POA) and Health Care Surrogate. Resident #2's son said, after his dad returned to the facility from the hospital his condition was fragile. The son explained, I did not return the facility or hospice's calls because I was not comfortable signing the DNR due to a conflict within the family where 3 of the 5 siblings in his family wanting resuscitation, but the others did not. On [DATE] at 2:45 PM, in an interview with the facility Social Services Director and Social Services Assistant. The assistant said, she had reviewed advanced directives with the son who had POA for financial and health after the resident returned from the hospital on [DATE]. She talked to the son over the phone on [DATE] and saw the resident as well who could not make his own decisions. She knew the hospice staff was working with the son regarding obtaining the DNR, however he had a large family, and it ultimately was a family decision. The Social Services Director explained the process that once the hospice had the DNR signed they would email or fax a copy to the facility and then she would immediately inform nursing staff of the resident's/family's wishes so they could be honored. The Social Services Director, who was the Abuse Coordinator, validated for nurses not to provide the care and services needed it was considered neglect. On [DATE] at 12:40 PM, a telephone interview was conducted with CNA D who worked on [DATE] on the , d+[DATE] PM shift. She was not resident #2's usual CNA and explained that earlier in her shift she saw the resident had shallow breathing. She recalled she checked on him every 30 minutes and asked LPN C about his breathing and was told by the nurse, he is passing on. The CNA verified the last time she saw the resident breathing was approximately 9:45 PM that night. She remembered that around 10:05 PM she informed LPN C he had passed because resident #2 was no longer breathing but verified he was not cold either. She stated the nurse got up right away and they both went into the resident's room. CNA D said she saw the nurse check for a pulse, take off the oxygen nasal cannula and then go back to the desk to talk with the supervisor. She did not see any of the nurses rush into resident #2's room to provide or assist with CPR, call a code or call for emergency services. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:53 AM, a telephone interview was conducted with assigned LPN C who explained she worked every weekend, double shifts from 7 AM to 3 PM and 3 PM to 11 PM. LPN C said she was not informed in the nursing report by the off going nurse that resident #2 was a Full Code. The off-going nurse only said told her he was not feeling well, slept most of the day and did not eat his lunch. During her shift she went to his room, and he only took a couple of sips of a nutritional shake that she offered. LPN C said, CNA D told me at 10:05 PM, the resident passed away, he was not moving at all and seemed like he expired. She then ran to the room with the blood pressure (BP) machine and verified he had no BP, and no pulse in his arm or neck. LPN C then a few minutes later had RN E, the supervisor come to the resident's room at 10:08 PM, who told her, He's dead. LPN C said she did not check resident #2's code status because her report sheet showed under code status he was hospice. She confirmed she failed to initiate CPR prior to getting supervisor RN E to come to the room. LPN C explained that even in a code situation she would not call 911 until approved by the supervisor because she was afraid of getting in trouble. LPN C said she knew she was supposed to check the computer for the resident's code status but did not because the computer was slow, instead she waited for the supervisor to come. LPN C denied any knowledge of a book at the nurses' station that contained residents' DNRO (Do Not Resuscitate Orders) nor did she check the book to ascertain resident #2's code status. While sitting at the nurses' station and calling the physician, family, hospice and finally the funeral home she found out resident #2 was a Full Code when she looked in the medical record and spoke to RN E about it. RN E told her since he was already dead, they didn't have to do CPR. LPN C said if she had known resident #2 was a Full Code she would have provided CPR and paged a code over the facility phone. LPN C again added that even in a code situation she would not have called 911 unless approved by a supervisor. On [DATE] at 12:05 PM, a telephone interview was conducted with RN E who was the Weekend Supervisor and usually worked from 7 AM to 11 PM on Saturday and Sunday. RN E verified that on [DATE] LPN C came to get him between 10:00 PM and 10:10 PM while he was shredding documents in the front office area near the lobby. He stated he was not at the nurse's station and because he was wearing earbuds and shredding documents, he could not hear anything. RN E explained LPN C came to the front of the building to get his attention, then he removed his earbuds, and she informed him resident #2 was dead. RN E recalled he went down to resident #2's room with LPN C and verified he was deceased by checking respirations, apical (chest), and radial (wrist) pulse which were not found. He explained he did not feel it was appropriate for him to initiate CPR since he was the 2nd nurse on the scene. He explained he knew the DNR was in process for resident #2 with hospice and the family and did not think it was reasonable to put the resident through being resuscitated. RN E notified the ADON via text message that resident #2 passed away that night but did not inform her the resident was a Full Code and had not received CPR. RN E said he did not have any conversations with facility administration regarding resident #2 not getting CPR until late yesterday afternoon when he was informed by the DON there was a major concern. RN E said he now knew that he should have provided CPR and informed ADON that night when the resident did not get CPR per his wishes and the physician order. The facility reported a complaint against LPN C to Florida Health Medical Quality Assurance (MQA) on [DATE] regarding the incident dated [DATE] which read, LPN, holding position of floor nurse, was called to resident's room .by assigned CNA related to resident was nonresponsive without respirations or pulse on [DATE] at approximately 10:08 PM .LPN did not follow Standards of Care related to verifying Code Status of resident. Resident was a Full Code and .LPN did not perform CPR. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility reported a complaint against RN E to Florida Health MQA on [DATE] due to incident dated [DATE] which read, RN, holding position of weekend supervisor, was called to resident's room .by assigned floor nurse related to resident was nonresponsive without respirations or pulse on [DATE] at approximately 10:08 PM . RN did not follow Standards of Care related to verifying Code Status of resident. Resident was a Full Code and .RN did not perform CPR and pronounced resident deceased . On [DATE] at 2:00 PM, the DON stated, nurses should know their residents' code status and they have to initiate a code if the resident is a Full Code. The DON acknowledged he was not informed that resident #2 did not get CPR until three days later on [DATE] during the survey. The DON explained he was not aware that resident #2's death was imminent and if he had known he could have gotten the medical director involved to call the son and try to get the DNR in place. Review of CNA D's employment records revealed signed acknowledgment she received the facility Abuse Prohibition Packet and Risk Management upon hire on [DATE]. She did computer training on Abuse, Neglect, and Exploitation: Mandatory Reporter on [DATE] and attended an in-person training on Abuse and Neglect on [DATE]. LPN C's records revealed she acknowledged receipt of the facility Abuse Prohibition and Risk Management packets upon hire on [DATE]. She had training via computer on Abuse, Neglect, and Exploitation: Mandatory Report on [DATE] and attended in-person training on Abuse and Neglect on [DATE]. RN E's records revealed he acknowledged receipt of the facility Risk Management and Abuse Prohibition Packet upon hire on [DATE]. He did computerized training on Abuse Neglect and Exploitation: Mandatory Reporter on [DATE] and attended in person inservice on Abuse and Neglect on [DATE]. According to recent education provided to staff between [DATE] and [DATE] regarding the facility's policies and procedures on Abuse/Neglect, neglect was defined as harming the person in your care; either physically, mentally, or emotionally by failing to provide needed care. Review of the immediate actions to remove the Immediate Jeopardy implemented by the facility as stated in their accepted Immediate Jeopardy Removal Plan revealed the following, which were verified by the surveyors: *On [DATE], the facility identified that resident #2 (who is deceased) had a code status of Full Code; however, on [DATE], upon finding resident#2 with no respirations or pulse, the facility nurse failed to initiate Cardiopulmonary Resuscitation (CPR) in accordance with the physician's order and the resident/resident representative's advanced directives in place at the time of the incident. *A root cause analysis was conducted using a combination of data collection methods, including interviews, surveys, and review of patient records. Conclusion: Root Cause was that the Resident's Code Status was not verified and CPR was not initiated by floor nurse or nurse supervisor. *On [DATE] at approximately 4:00 PM, the facility initiated an investigation. Self-report called into Department of Children and Family Services/Adult protective services and an Immediate report sent into the State Agency at approximately 6:45 PM by Abuse Coordinator. The LPN involved in the incident provided a statement and was suspended per facility policy pending investigation. The supervisor involved in the incident provided a statement and was suspended per facility policy pending investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*On [DATE], the facility began re-education of all facility staff on Abuse/Neglect. As of [DATE], 119 of 182 staff members have received education (documentation obtained). Education is at 65% and will remain ongoing until all staff members, including part-time and PRN (as needed) staff, are educated prior to the next scheduled shift. *On [DATE] Emergency Quality Assurance Performance Improvement (QAPI) Meeting held to discuss problem identified and immediate actions needed, as noted above, with QAPI team present in person and Medical Director via telephone. *On [DATE] the Medical Director reviewed emergency QAPI on paper and signed off. *On [DATE] Licenses of LPN and RN Supervisor who did not initiate CPR reported to the Board of Nursing and were relieved of employment. Staff interviews conducted on [DATE] included 8 CNAs and 8 licensed nurses (4 RNs and 4 LPNs) revealed all were knowledgeable regarding the facility's Abuse/Neglect policies and procedures including definition of neglect and immediate reporting. Staff verbalized knowledge that failure to provide care and services meets the definition of neglect.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to ensure staff reported neglect of a resident related to not performing cardiopulmonary resuscitation (CPR) to the Risk Manager or Administrator which resulted in late reporting to the State Agency and Adult Protective Services for 1 of 2 residents reviewed for neglect, of a total sample of 8 residents, (#2). Findings: Resident #2 was re- admitted to the facility from the hospital on [DATE] with diagnoses that included dementia, cerebrovascular disease and adult failure to thrive. The medical record revealed he was readmitted on hospice services. Progress notes dated [DATE] at 10:40 PM and 11:16 PM, revealed that at approximately 10:05 PM, Licensed Practical Nurse (LPN) C was notified by the Certified Nursing Assistant (CNA) that resident #2 was not breathing. LPN C assessed the resident and found he had no pulse or blood pressure. The note did not indicate that she checked the resident's code status and initiated CPR as per the physican order, but instead went to notify the Weekend Supervisor Registered Nurse (RN) E at the front of the building. RN E immediately went to the resident's room and confirmed he had no vital signs, but also failed to initiate or provide CPR. The facility staff failed to follow the physician order, and their policies and procedures for CPR by not checking the resident's code status. They failed to immediately report the incident once they realized the neglected to perform CPR as ordered to the appropriate facility staff. As a result of this failure the facility failed to report the possible neglect within the required time frames. On [DATE] at 12:05 PM, the Weekend Supervisor RN E stated that after resident #2's death he called the Assistant Director of Nursing (ADON) and the resident's family member to let them know that the resident had expired but he confirmed he failed to mention that CPR had not been performed even though the resident had an order for a Full Code. RN E stated he was aware that resident #2 was on hospice and stated he felt it was inappropriate to attempt CPR due to the resident's declining state. He later acknowledged that not following the physician's orders and the resident's wishes was neglect. RN E said that looking back at the situation he would have called a code, performed CPR, and reported that LPN C did not perform CPR as ordered to the ADON. He further confirmed he had previously received education on reporting all abuse, neglect, misappropriation, or suspected criminal activity within 2 hours of the occurrence regardless of whether the situation met the requirements for reporting. On [DATE] at 2:00 PM, the Director of Nursing (DON) said that staff were supposed to report suspected abuse or neglect to the Social Services Director who was the Abuse Coordinator, but when the Social Services Director was not available, they could report to either the Nursing Home Administrator, Risk Manager/ ADON, or to the DON. She confirmed the Weekend Supervisor, RN E, should have informed the ADON, when he called her to report the death, that CPR had not been provided for resident #2 even though there was an order for a full code. The DON said the expectation was for staff to report any suspected abuse, neglect, or misappropriation of property per facility policies and procedures. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:45 PM, the Social Service Director confirmed she was the facility's Abuse Coordinator. She explained that resident #2 was readmitted to the facility on [DATE] from the hospital and the hospice election form had been signed prior to his return on [DATE]. The Social Service Director stated resident #2 remained a Full Code as per his family's wishes due to disagreements within the family about making him a Do Not Resuscitate (DNR). The Social Service Director said that at the time of the resident's passing, he was still a Full Code and therefore CPR should have been performed. The Social Service Director validated that the nurses did not provide the care and services for the resident which was considered neglect. She acknowledged RN E should have reported LPN C to her or the Administrator the moment he realized the resident was a Full Code, and CPR was not performed. Review of the facility's undated document with the policies and procedures Abuse/Neglect, neglect was defined as harming the person in your care; either physically, mentally, or emotionally by failing to provide needed care. It further stated that any allegations or suspicions of abuse or neglect must be reported immediately and listed the ADON/Risk Manager, and the Abuse Coordinator/Social Service Director.

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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** 35086 Based on interview, and record review, the facility failed to honor the resident's/family's wishes and failed to follow the physician's order to provide basic life support (BLS) and initiate Cardiopulmonary Resuscitation (CPR) for 1 of 6 residents reviewed for Advanced Directives, of a total sample of 8 residents, (#2). On [DATE] at approximately 10:05 PM, resident #2 was found unresponsive in bed, not breathing by Certified Nursing Assistant (CNA) D. The CNA notified Licensed Practical Nurse (LPN) C who evaluated the resident had no vital signs. LPN C did not verify the resident's code status, or initiate CPR and instead asked Registered Nurse (RN) Supervisor E at approximately 10:08 PM to come to the resident's room. RN E evaluated resident #2 with no vital signs, disregarded the physician order for Full Code or Full Resuscitation status and did not initiate CPR. The facility's failure to ensure staff followed the resident/family's wishes and physician's order to initiate CPR resulted in Immediate Jeopardy starting on [DATE]. Immediate Jeopardy was removed on [DATE] and the scope and severity of the deficiencies were decreased to D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings: Cross Reference F600 Resident #2, an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital with diagnoses of dementia, psychotic disturbance, cerebrovascular disease (stroke), sepsis, influenza A with pneumonia, atrial fibrillation (irregular heartbeat), chronic kidney disease, muscle weakness, dysphagia (difficulty swallowing) and adult failure to thrive. Review of resident #2's Annual Minimum Data Set, dated dated dated [DATE] revealed he had a Brief Interview of Mental Status score of 1 out of 15 indicating he was severely cognitively impaired. Review of the resident's care plan for Advanced Directives revised on [DATE] read, He is a Full Code status with goal that Advanced Directives will be honored as written. Review of the facility's resident rights policies and procedures for Advanced Directives, dated ,d+[DATE] read, Advance directives will be respected in accordance with state law and facility policy .Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an Advanced Directive if he or she chooses to do so .If the resident is incapacitated and unable to receive information about his or her right to formulate Advance Directive, the information may be provided the resident's legal representative .The plan of care for each resident will be consistent with his or her documented treatment preferences and/or Advance Directive . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Emergency Procedure-Cardiopulmonary Resuscitation policy and procedure dated , d+[DATE] read, If a resident is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless. a. It is know that a Do Not Resuscitate [DNR]order that specifically prohibits CPR . If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR . On [DATE] LPN A documented, Resident returned to the facility at approximately 7:49 PM on stretcher, via medical transport and two [2] medical personnel . Resident is FULL CODE . On [DATE] at 1:09 PM, the facility Social Services Assistant documented, readmitted to facility from hospital stay. He's currently on .hospice services .continues as a full code status . On [DATE] at 4:53 PM, a telephone interview was conducted with hospice RN F and Social Worker G who saw resident #2 at the facility on [DATE]. The hospice staff explained they had extensive conversations with resident #2's son and the Social Worker sent him the DNR form, and he was going to send it back to hospice once the siblings agreed. RN F explained she sat down with the facility South Wing Unit Manager and told her on [DATE], As of this movement he is a Full Code, and we must maintain code status until we see the DNR. He can be on hospice and a Full Code. The hospice nurse indicated she had a serious conversation as well with the son who requested some time to talk to his siblings. On [DATE] at 5:03 PM, a telephone interview was conducted with resident #2's son who verified he was the Power of Attorney (POA) and health care surrogate for his father. Resident #2's son said after his dad returned to the facility from the hospital his condition was fragile. The son explained, I did not return the facility's or hospice's calls because I was not comfortable signing the DNR due to 3 of the 5 siblings in his family wanting resuscitation and 2 of them did not. On [DATE] at 2:06 PM, Advance Practice Registered Nurse (APRN) B documented a visit note that the resident was on hospice and had Full Code status. On [DATE] at 3:13 PM, APRN B said she last saw resident #2 on [DATE] and did not think he was dying. She explained at that time his son was feeding him soup. The APRN said she was unable to comment and needed further information from the facility,when she was asked about staff not providing CPR to resident #2 when he had Full Code orders. On [DATE] at 2:45 PM, in an interview with the Social Services Director and Social Services Assistant, the assistant said she reviewed Advance Directives with the son who had POA for financial and health matters after the resident returned from the hospital on [DATE]. She explained she talked to the son over the phone on [DATE] and saw the resident as well who could not make his own decisions. She said she knew the hospice staff was working with the son regarding obtaining the DNR, however he also had a large family, and it was a family decision. The Social Services Director explained the process that once the hospice had the DNR signed by the POA and the physician, they would email or fax a copy to the facility and then she would immediately inform nursing staff of the resident's/family's wishes so they could be honored. (continued on next page)

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	105839	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:40 PM, a telephone interview was conducted with CNA D who worked on [DATE] on the 3 PM to 11 PM shift. She said she was not resident #2's usual CNA and recalled that earlier in her shift she saw the resident had shallow breathing. She explained she checked on him every 30 minutes and had asked LPN C about his breathing and was told, he is passing on. The CNA verified the last time she saw the resident breathing was approximately 9:45 PM that night. She recalled that about 10:05 PM she informed LPN C resident #2 had passed because he was no longer breathing at all. She remembered resident #2 was still warm when she went to tell LPN C of what happened. She said she saw the nurse get up and they both went into the resident's room. CNA D said she saw the nurse check for a pulse, take off the oxygen nasal cannula and then go back to talk with the Supervisor. She did not see any of the other nurses' rush into resident #2's room to provide assistance with CPR. She then saw LPN C and Supervisor RN E at the nurses' station making phone calls. CNA D verified she had CPR training and could have assisted with calling the code over facility intercom and 911 emergency services had she been directed by the nurse. On [DATE] LPN C documented, at 10:05 PM, the CNA had called to let her know that she thought resident #2 had died . She wrote, Nurse went to room and find [resident #2] died . Shift supervisor called right away at 10:08, PCP [primary care provider] made aware at 10:15 PM. Son called at 10:20 PM. Hospice also called. At this time, body still in bed waiting for final decision by family and hospice. On [DATE] at 10:53 AM, a telephone interview was conducted with LPN C who was assigned to resident #2 on [DATE]. She explained she worked double shifts every weekend from 7 AM to 3 PM and 3 PM to 11 PM. LPN C said she was not informed in the nursing report by the off going nurse that he was a Full Code. The off-going nurse only said that he was not feeling well, slept most of the day and did not eat his lunch. During her shift she went to his room, and he only took a couple of sips of nutritional shake that she offered. LPN C said, CNA D told me at 10:05 PM the resident had passed away, he was not moving at all and seemed like he expired. She recalled she then ran to the room with the blood pressure (BP) machine and verified he had no BP, and no pulse in his arm or neck. LPN C said she then had RN E the supervisor come to the resident's room at 10:08 PM and he told her, he's dead. LPN C said she did not check resident #2's code status because her report sheet showed under code status he was hospice. She acknowledged she failed to initiate CPR prior to getting supervisor RN E to come to the room. LPN C explained that even in a code situation she would not call 911 until approved by supervisor because she was afraid of getting in trouble. LPN C said she knew she was supposed to check the computer for the resident code status and did not because the computer was slow, so she waited for the supervisor to come. LPN C denied any knowledge of a book at the nurses' station that contained the residents' DNRO (Do Not Resuscitate Orders) nor did she the check book to ascertain resident #2's code status. LPN C said while she was at the nurses' station she called the physician, the family, hospice and the funeral home. She discovered resident #2 had Full Code orders when she looked in the medical record and spoke to RN E about it. RN E told her since he was already dead, they didn't have to do it. LPN C acknowledged she should have provided CPR and paged the code over the facility phone, however she stated she still would not have called 911/emergency services unless approved by the supervisor even in a code situation. On [DATE] at 10:05 PM, RN E documented, Summoned to resident room. Resident has ceased to breathe. HR [heartrate] 0. Resident pronounced dead at 10:05 PM. On call .made aware as well as ADON [Assistant Director of Nursing] and .Hospice. Family notified of resident passing and verify funeral home (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:05 PM, a telephone interview was conducted with RN E who was the Weekend Supervisor and usually worked from 7:00 AM to 11:00 PM on Saturdays and Sundays. RN E verified that on [DATE] LPN C asked him to come to resident #2's room, between 10:00 to 10:10 PM while he was shredding documents in the front office area near the lobby and not at the nurse's station. RN E said he had earbuds in and could not hear anything until he took out his earbuds and LPN C said, resident #2 was dead. He then went to the resident's room with LPN C and checked resident #2's respirations, apical (chest), and radial (wrist) pulse and found there were none. RN E stated he verified resident #2 was deceased and he thought he had been down for little bit. He explained he did not feel that it was appropriate for him to initiate CPR since he was the 2nd nurse on the scene. He recalled he knew the DNR was in process for resident #2 with hospice/family and did not think it was reasonable to put the resident through being resuscitated. RN E stated he notified the Assistant Director of Nursing (ADON) via text message that resident #2 passed away that night but did not inform her the resident had orders for Full Code and did not receive CPR. RN E said he did not have any conversations with facility administration regarding resident #2 not getting CPR until late yesterday afternoon. He was informed by the Director of Nursing (DON) that there was a major concern. RN E said he now knew he should have provided CPR to resident #2 and he should have informed the ADON right away that the first nurse that found him did not initiate/perform CPR per the physican orders. Review of CNA D's employment record revealed she had completed BLS training through the American Heart Association on [DATE]. BLS training was in effect for two years exceeding the issue date and was not due to renew till ,d+[DATE]. Review of LPN C's employment record revealed she had completed BLS training through the American Heart Associate on [DATE]. Review of RN E's employment record did not reveal current BLS training present as requested at the time of the survey. On [DATE] at 2:00 PM, the DON stated, nurses should know their resident code status and they have to initiate a code if the resident is a full code. The DON acknowledged that he was not informed that resident #2 did not get CPR until [DATE] when informed at the time of survey. The DON explained he was not aware that resident #2 was close to death and said if he had known he could have gotten the medical director involved to call the son and try to get DNR in place. The facility reported a complaint against LPN C to Florida Health Medical Quality Assurance (MQA) on [DATE] regarding incident dated [DATE] which read, LPN, holding position of floor nurse, was called to resident's room .by assigned CNA related to resident was nonresponsive without respirations or pulse on [DATE] at approximately 10:08 pm .LPN did not follow Standards of Care related to verifying Code Status of resident. Resident was a Full Code and .LPN did not perform CPR. The facility reported a complaint against RN E to Florida Health MQA on [DATE] due to incident dated [DATE] which read, RN, holding position of weekend supervisor, was called to resident's room .by assigned floor nurse related to resident was nonresponsive without respirations or pulse on [DATE] at approximately 10:08 pm . RN did not follow Standards of Care related to verifying Code Status of resident. Resident was a Full Code and .RN did not perform CPR and pronounced resident deceased . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Facility Assessment last updated [DATE] revealed the facility provided services and care based on residents' needs. The staff training/education/competencies were ongoing, and topics included Resident Rights, Abuse/Neglect/Exploitation and Advanced Care Planning. The facility was responsible for ensuring staff were educated on these topics, their responsibility to properly care for its residents and procedures for reporting incidents. Review of the immediate actions to remove the Immediate Jeopardy implemented by the facility as stated in their accepted Immediate Jeopardy Removal Plan revealed the following, which were verified by the surveyors: * On [DATE], the facility identified that resident #2 (who is deceased) had a code status of Full Code; however, on [DATE], upon finding resident#2 with no respirations or pulse, the facility nurse failed to initiate CPR in accordance with the physician's order and the resident/resident representative's advanced directives in place at the time of the incident. * A root cause analysis was conducted using a combination of data collection methods, including interviews, surveys, and review of patient records. Conclusion: Root Cause is that the Resident's Code Status was not verified and CPR was not initiated by floor nurse or nurse supervisor. * Upon identification, on [DATE] at approximately 4:00 PM, the facility initiated an investigation. Self-report called to law enforcement and Adult Protective Services on [DATE] at approximately 5:48 PM by Abuse Coordinator and per Adult Protective Services no report was generated. Immediate report sent to State Agency at approximately 6:45 PM by Abuse Coordinator. * On [DATE] the facility conducted audited 4 of 4 current residents who were under hospice care. Three of the 4 residents were DNR and 1 was Full Code. The Social Services Director spoke with the family of the resident who was a Full Code, and the family wished to continue with the same status. * On [DATE] the Social Services Director completed an audit of all in-house residents to ensure physician's code status order, face sheet, care plans and documentation of resident's advanced directives matched all matched. * On [DATE] an emergency Quality Assurance Performance Improvement (QAPI) meeting was held to discuss problems identified and immediate actions needed, with the QAPI team present in person and the Medical Director via telephone. * On [DATE] the Medical Director reviewed the emergency QAPI meeting on paper and signed off. * On [DATE] licenses of nurses who did not initiate CPR were reported to the Board of Nursing. *On [DATE] Mock Code Blue Drills performed for all licensed nursing staff for night shift and day shift. The , d+[DATE] PM shift will be completed on [DATE]; then going forward to be continued all 3 shifts each week times 4 weeks; all 3 shifts each month times 12 months. * On [DATE] re-education on Code Blue/CPR Policy/Protocol initiated. Education was at 45% completed with 49 of 109 licensed nurses completed and will remain ongoing until all staff members including part-time and PRN (as needed) staff are educated prior to the next scheduled shift. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff interviews conducted on [DATE] included 8 CNAs and 8 licensed nurses (4 RNs and 4 LPNs) revealed all were knowledgeable regarding the facility's Advance Directive and CPR Policies.