STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105952	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Grand Oaks	3001 Palm Coast Parkway SE Palm Coast, FL 32137

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - 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, facility reports, staff interviews, and the facility's policies and procedures titled Advance Directives and Florida Cardiopulmonary Resuscitation (CPR), the facility failed to act in accordance with the resident's Advance Directives and his Full Code status (the desire to be resuscitated in the event of cardiac/respiratory arrest) after finding him unresponsive with no respirations. This affected one (Resident #1) of three residents reviewed for Advance Directives. The facility's failure to honor Resident #1's Advance Directives deprived him of potentially lifesaving measures. Resident #1 was not revived and expired in the facility. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 1:34 p.m. on [DATE]. On [DATE], at 7:35 a.m., Immediate Jeopardy began. On [DATE], at 5:30 p.m., the Interim Administrator/Associate Regional [NAME] President of Operations (ARVPO) 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 failing to provide cardiopulmonary resuscitation (CPR) to a resident with a CPR order. The findings include: Cross Reference F678 A closed record review for Resident #1 found he was admitted to the facility from an acute care hospital on [DATE] for short-term skilled care, with an expected discharge home with his spouse. He had diagnoses including acute systolic congestive heart failure (the left ventricle cannot contract normally), chronic respiratory failure with hypercapnia (the body has too much carbon dioxide in the blood and cannot rid itself of the excess), acute pulmonary edema (fluid buildup in the lungs making it difficult to breathe), chronic obstructive pulmonary disease (COPD, lung disease causing restricted airflow and breathing problems), and atherosclerotic heart disease of the native coronary artery without angina pectoris (a buildup of plaque on the inner walls of the heart arteries, causing narrowing and blocking blood flow, without chest pain). (continued on next page)

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	A review of the Death in Facility Minimum Data Set (MDS) assessment with a reference date of [DATE], revealed that Resident #1 expired on [DATE]. A review of the resident's medical record revealed physician's orders dated [DATE] for Full Code Status and a plan to discharge home. (Photographic evidence obtained) A review of the medical record's nursing progress notes revealed the following: On [DATE] at 10:04 a.m., Registered Nurse (RN) A/Weekend Supervisor (in training) charted that at approximately 7:35 a.m., a code (Code Blue - used to announce a resident is unresponsive) and 911 were called for Resident #1. RN A immediately responded and assessed the resident to be pulseless, apneic (involuntarily and temporarily stopped breathing), unresponsive, and cool to the touch. It was noted that CPR was performed for approximately 15 minutes. Code called by this RN. Calls placed to ADON (Assistant Director of Nursing) and DON (Director of Nursing). EMS (Emergency Medical Services) entered the building at approximately 8:15 a.m . at 8:20 a.m. as deceased (sentence incomplete). Call placed to wife. (Photographic evidence obtained) On [DATE] at 5:15 p.m., Licensed Practical Nurse (LPN) B noted that the CNA (Certified Nursing Assistant A) for Resident #1 entered his room and found the resident unresponsive. CNA A advised LPN B, who immediately checked the chart for a Do Not Resuscitate (DNR) status while the nurse on the 200 hall, LPN A, called the Code Blue and 911. The resident did not have a DNRO (do not resuscitate order). CPR was started and continued for five rounds, for approximately 15 minutes until 7:50 a.m. Patient's body was stiff and rigid. Cold to touch. Registered Nurse (RN) on duty notified the ADON and Administrator. Re-started CPR at 7:54 AM. EMS re-called; patient pronounced deceased 8:20 a.m. (Photographic evidence obtained) A review of a facility report generated by the Nursing Home Administrator (NHA) on [DATE] at 6:48 p.m. alleging neglect, declared that on [DATE] at approximately 7:35 a.m., Resident #1 was observed by CNA A to be unresponsive. CNA A notified LPN B, who immediately retrieved Resident #1's medical record and discovered the resident was a Full Code. LPN A verified the Full Code status, paged Code Blue on the overhead speaker and notified 911. LPN B went to the room and RN A arrived with the crash cart. RN A assessed the resident as cool to the touch, pulseless, and apneic. His digits were blue. CPR was immediately initiated and performed for approximately five rounds/15 minutes. RN A then stopped CPR to notify the NHA of the incident but was instructed to continue CPR. The CPR was stopped for approximately , d+[DATE] minutes, then resumed. EMS (emergency medical services) arrived at the facility and placed leads on the resident, who was found to be without a pulse. EMS pronounced the resident deceased at 8:20 a.m. An update to the report on [DATE] at 9:56 p.m. revealed that from [DATE] to [DATE] between the hours of 11:00 p.m. and 6:00 a.m., CNA B stated Resident #1 was seen at 11:00 p.m., then called for assistance at 12:30 a.m. and again at 3:00 a.m. At 6:00 a.m., the resident was noted to be sleeping in his bed. On [DATE] at 5:00 a.m., LPN F stated I was in there often throughout the night. He kept taking his CPAP off. His O2 (oxygen) sat (saturation) was ,d+[DATE]%, but he kept taking it off, and I kept redirecting him. At 5:00 a.m., I gave him meds (medications) and he was fine. He wasn't wearing the mask, but he was awake. (Photographic evidence obtained) As part of the facility's investigation, written statements from licensed staff on duty the morning of [DATE] were obtained. A review of the statements revealed the following: (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA A noted that she started passing drinks at 7:30 a.m. in room [ROOM NUMBER]. When she got to [Resident #1's] room, she tapped his foot, called his name and shook his arm, but got no response. She told LPN B he was not responding. By the time she got back to the room, RN A entered. CNA A waited outside until ordered by RN A to start post-mortem (after death) care. RN A noted that Resident #1 was pulseless, apneic, unresponsive, and cool to touch. CPR was performed for approximately 15 minutes. RN A called the code, and the ADON and DON were called immediately. EMS entered the building at approximately 8:15 a.m. and pronounced the patient deceased at 8:20 a.m. In a second written statement by RN A, also on [DATE], she added that Resident #1 was apneic, pulseless, cool to the touch, and with blue lips, fingers, toes and ears. CPR was performed per protocol and despite the RN's assessment, for approximately 15 minutes. Resident #1's oxygen was running but the nasal cannula was not on his face. RN A pronounced the resident deceased secondary to no life response. She turned EMS away the first time they arrived, as she was unaware that she was not permitted per facility protocol to pronounce a resident deceased . She dispatched EMS again, and they returned at 8:15 a.m. EMS assessed the resident as deceased and pronounced his death at 8:20 a.m. In a second written statement on this day by RN A, she added that she conducted CPR for 15 minutes, then pronounced the resident's death. LPN B wrote that CNA A advised her that Resident #1 was unresponsive. LPN B checked the chart while LPN A called 911. The resident did not have a Do Not Resuscitate Order (DNRO). CPR was started for five rounds for approximately 15 minutes until 7:50 a.m. The resident's body was stiff and cold to the touch. RN A notified the ADON and NHA. CPR was restarted at 7:54 a.m. EMS was called and pronounced the resident's death at 8:20 a.m. LPN A wrote that while passing medication on the 200 hall, the 500 hall nurse told her a CNA advised that the Resident #1 was expired. She immediately ran to check the chart for the resident's code status, then called 911. While on the phone with 911, the nurse supervisor (RN A) came and told her she had it handled. LPN D wrote that when she responded to the hall for the Code Blue call, the RN supervisor told her she was not needed. LPN C noted that she heard the overhead page and ran to check the resident's chart, but they were already checking. Then the nurse supervisor stated they had it handled. The NHA noted that she called the county's Emergency Medical Services to request reports. She was advised that they were dispatched at 7:50 a.m. for CPR in progress but were made aware that the resident had rigor and the nurse had called it, so they left. They were called back 15 minutes later as CPR had been resumed, since they (the nurse) were unable to pronounce the resident's death. When EMS arrived, they placed two leads on the resident and pronounced him deceased at 8:20 a.m. LPN E wrote that she heard the Code Blue announced and walked toward 500 East. Her partner nurse was coming back and said, they don't need us. She then noticed the 911 truck and went to see what happened. The RN supervisor (RN A) was walking out of the room and told East Wing staff to cancel 911, he is already cold. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Photographic evidence of all statements obtained) On [DATE], additional statements from follow-up interviews were noted by the ADON and revealed the following: RN A explained that her new employee orientation Friday ([DATE]) was fast because the facility needed her. She got no training, just a stack of papers to sign, and then was sent with LPN A to shadow her on the medication cart. On Sunday ([DATE]), she heard the Code Blue called and responded, finding Resident #1 lifeless. She sent responding nurses away because there was nothing to code. No one wanted to take charge, and everyone was looking at her for what to do. She did the best she knew how to do. RN A said she had pronounced bodies 100 times. After turning EMS away, the other nurses told her she shouldn't have done that. RN A asked why not, pointing out the fact that the resident was expired. RN A left the room and texted the NHA, DON and ADON. When they arrived, everyone started taking statements. LPN B told RN A the NHA said they had to lie and say they did CPR, or they could lose their licenses. CPR was never done, not once. RN A said, I wouldn't do that to a dead body; you wouldn't want that done to your loved one. LPN B admitted everything she said in her previous statement was true but added that she was told by the NHA to say they did CPR, or she would lose her license. LPN B admitted they never performed CPR, as the resident had been dead for a long time. RN A pronounced his death and said it would be defiling a body to do CPR. LPN B wrote that EMS said the resident had to have been dead for two to three hours. RN A pronounced his death at around 7:48 a.m. LPN D explained that she was the 400 hall nurse and responded to the Code Blue overhead page. She went to the resident's room and RN A reported the patient died , nothing could be done, and LPN D wasn't needed. LPN D asked, Don't we have to do CPR? RN A advised, He's been dead for a while and there's nothing we can do. I pronounced him. LPN D returned to her unit. CNA C stated she heard the Code Blue and responded. There were five CNAs outside of the resident's door and two nurses were in the room; one was the RN supervisor (RN A). CNA C asked, Are we doing anything? No one responded. The RN supervisor came out of the room and said there was nothing they could do; he'd been gone too long. (Photographic evidence of all statements obtained) On [DATE], the Regional [NAME] President of Operations (RVPO) generated a follow-up facility report that included an analysis of the event and detailed the findings of the facility's investigation. In the summary of interviews conducted, the newly identified discrepancies from the original witness statements were noted. They were summarized as follows: LPN B now stated that on [DATE] at 7:30 a.m., after responding to the resident's room, the RN on duty was in the room and said the resident was expired, had been dead, and there was nothing to code. LPN B told the RN the resident was a full code. The RN said, There is nothing to code.; that (performing CPR) would be defiling a body. The RN directed the CNAs to start post-mortem care and stated she would notify everyone and had it handled. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN A heard a Code Blue called and ran to the resident's room. The resident's oxygen tubing was on the floor with the oxygen concentrator running. The resident was lying supine (on his back) with no pulse, no respirations, no response, stiff, cold to touch, lips, ears, fingers and feet were all blue. RN A applied a stethoscope for apical pulse; none was noted for one minute and still no respirations. RN A stayed in the room until EMS arrived for the first code. She stopped them to report the resident was deceased . Nurses were responding to the room, but RN A sent them away because there was nothing to code. CPR was never done, not once. (Photographic evidence of both statements obtained) The report's conclusion was that as a result of the investigation which had been conducted by the Regional Nurse Consultant (RNC), the allegation of neglect was substantiated. (Photographic evidence obtained) A review of the facility's policy and procedure for Advanced Directives (document SS-124, effective [DATE] and revised [DATE]) revealed: Policy: The center will abide by state and federal laws regarding Advance Directives. The center will honor all properly executed Advance Directives that have been provided by the resident and/or resident representative. Process: 1. Upon admission, Social Service Director or Business Development Coordinator/designee will: a) Communicate to resident and/or resident representative his or her right to make choices concerning health care and treatments, including life sustaining treatments. 4. Upon completion of the Advanced Directives Discussion Document, Social Services or nurse will notify the Physician of the resident ' s wishes and procure a state approved Do Not Resuscitate Order, if necessary. Notification will be documented in the medical record. 5. Advanced Directives will be reviewed: - Quarterly - Hospice Admission - Additional times as needed or requested by the resident/resident representative. Reviews are designed to: Identify and clarify the content and intent of the existing care instructions, and whether the resident wishes to change or continue these instructions. Identify situations where health care decision-making is needed. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review the resident ' s condition, mental capacity to make health care decisions, and existing choices and continue or modify approaches. Any changes to Advanced Directives will require a new Advanced Directives Discussion Document to be completed and placed in the medical record. The previous document to be filed in the thinned record. (Photographic evidence obtained) The facility's policy and procedure titled Florida Cardiopulmonary Resuscitation (CPR) (document N-301 effective [DATE], revised [DATE]) revealed: Policy: Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a fully executed Florida Do Not Resuscitate (DNR) order. Procedure: 1. In the event of cardiac arrest, immediately call for assistance. 4. In the absence of a fully executed Florida Do Not Resuscitate order (DH1896), the facility will immediately begin CPR. 5. Center staff will continue performing CPR until Emergency Medical Technicians assume responsibility for CPR, or it may be discontinued if: - The resident responds. (Photographic evidence obtained) An interview was conducted with the Director of Nursing (DON) on [DATE] at 3:05 p.m. She advised that she was not present the day of the event but said RN A was supposed to be in orientation. She chose to take herself off orientation and help out on the floor. Company policy when finding a resident unresponsive is to check the code status, call Code Blue, and perform CPR (if full code) until EMS arrives, even if there are apparent signs of death. EMS will put the leads on and make that call. Nurses are not allowed to pronounce residents' deaths. An interview with CNA A on [DATE] at 7:10 a.m., revealed that on [DATE], she was assigned to rooms 504 to 509 and began her shift with passing drinks. At approximately 7:30 a.m., upon arriving at room [ROOM NUMBER], she greeted Resident #1, but there was no response. He appeared to be sleeping, but when she lifted his hand it just dropped, and he felt cold. She alerted CNA D, who confirmed Resident #1 appeared deceased , and together they notified LPN B. When CNA A, CNA D, and LPN B arrived back at Resident #1's room, RN A was already there. LPN B announced that the resident was a full code, however RN A refused to perform CPR and ordered CNA A and CNA D to start post-mortem care. EMS was seen outside the door but was leaving without entering the room. While providing post-mortem care, RN A announced, CPR should've been performed and EMS allowed in. She then stood over Resident #1 and performed pretend CPR with hand movements over his body. EMS returned and were informed by the nursing staff that CPR was performed for three minutes, however, CPR was never performed. Later, CNA A reported she was approached by LPN B, who stated they needed to keep their stories straight, and say CPR was performed for three minutes. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The RNC contributed, explaining that following the incident, an Ad Hoc QAPI meeting was conducted on [DATE] and the PIP was developed. The data was gathered, and a root cause analysis was determined. Initially, the root cause analysis focused on a lack of orientation training for RN A, the new supervisor. This was the primary focus. RN A was oriented on Friday and was supposed to be orienting that Sunday but ran off on her own. That is where they felt maybe they could have done something differently. In response, all resident code statuses were checked and found to be accurate. The initiation of the Code Blue response the day of the incident was also deemed correct. But then, the false information presented and forced a revisit. Another Ad Hoc QAPI meeting was conducted on [DATE] with the discovery of false information. False documentation was also identified. A separate plan was developed to focus on ethics and compliance; how to now address unethical behavior and staff response. Being the only RN in the building on the day of the event, staff felt it would be insubordination to reject her directives. They were re-educated on that. Staff were trained on Advance Directives (AD), and they made sure all licensed staff were aware of what that meant, as well as the situations during which Advance Directives should be honored. Staff were trained in the facility's CPR policy, including when to start CPR. An audit of CPR certifications for nurses was performed and now all nurses were American Heart Association (AHA) certified. Abuse and neglect training was provided building wide. Scheduled deviations were covered too, since RN A had effectively removed herself from facility orientation. The ARVPO added the focus was currently on policing themselves and resulted in another root cause analysis and evaluation of processes. The second QAPI was conducted about the corporate compliance program with a focus on staff notification (of non-compliance) and filing concerns without fear of retaliation. It also included what to do if someone asked a staff member to do something unethical. Code blue drills were still being conducted with all licensed staff participating. Staff had been retrained, or received the information packet, on Code Blue response and drills. There was a QAPI meeting scheduled for tomorrow ([DATE]), and the PIP would be re-evaluated. Weekly Advance Directive audits were being conducted, and the facility would continue reviewing nurses' CPR status and licensure. This was all added to the orientation process. Classroom training for new nurses would be audited to ensure completion. CPR tests were provided to validate the nurses' understanding of policies with 100% of nurses passing. On [DATE] at 1:03 p.m., LPN B was interviewed and explained that on the day of the event, RN A was training with her. The CNA came and told her that Resident #1 was deceased and stiff. One nurse called the Code Blue, and someone called EMS. LPN B went to the room after RN A ran in. The resident was in full 100% rigor, stiff as a board, and had been dead for a while. RN A decided there was nothing they could do. Nothing would have brought him back; they would have broken all the bones in his body (had they initiated CPR). It was too late. LPN B admitted they did not perform CPR. She told RN A that facility protocol was to provide CPR. RN A called the NHA who instructed her to call medics and get back in the room and perform CPR. It had been 30 minutes since they had discovered the body at this point. The NHA was more concerned about what was going to happen to the facility and wanted RN A to lie. When the NHA arrived at the facility that day, she told LPN B, You know, this could affect your license. She threatened LPN B that she would lose her nursing license. The NHA insinuated that they had to lie and was asking pointed questions such as, This happened, right? LPN B said she felt cornered and threatened, as though she had no choice but to do what the NHA wanted her to do. Then the NHA would not let LPN B leave until she went over her documentation to make sure it included everything the NHA wanted it to include. She stated again that no one ever started CPR. The resident was in full rigor. When EMS came back, they said he had been dead for at least three hours. LPN B told the truth when she talked to the RNC. She stated, Was it wrong for me to document what I did? Yes, it was. LPN B concluded, saying she was afraid not to follow the NHA's instructions. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ADON was interviewed on [DATE] at 2:25 p.m. She recalled being in bed the morning of the event and receiving a message from RN A. RN A reported finding Resident #1 and pronouncing his death. The ADON and NHA arrived at the facility around 9:00 a.m. and interviewed LPN B. LPN B was initially vague about what happened, then the NHA said, This is your resident, he was your responsibility, you need to explain what happened. LPN B then said after CNA A found Resident #1 deceased , RN A went to the room. LPN B went for the chart and LPN A paged the Code Blue. LPN B said they then performed the required five rounds/15 minutes of CPR on Resident #1. The ADON had never heard of this required 5 rounds of CPR, but LPN B repeated this several times. LPN B said due to obvious signs of death, RN A pronounced the resident. RN A called the NHA and was advised to resume CPR, so she returned to the room. They reportedly resumed compressions until paramedics arrived. The ADON and NHA interviewed RN A, who told the same story about the required five rounds/15 minutes of CPR before pronouncing Resident #1's death. After going home that evening and thinking about the timelines more closely, the ADON realized they did not line up. The CNA's testimony did not line up with 15 rounds of CPR being performed and the time the phone call came from RN A that she had pronounced the resident's death. There was no way five rounds could have been performed. On Monday ([DATE]), the ADON reported this to the NHA, and they called corporate and reported their suspicion that CPR had not been performed. The RNC arrived on Tuesday to take over the investigation. Upon speaking with the CNA, she admitted CPR was not performed. Instead, the nurses stood over the body arguing. LPN B and RN A eventually admitted this too in subsequent interviews. RN A was interviewed on [DATE] at 3:45 p.m. She said this was the first time she had experienced anything like this. Her background was in hospitals, home health and acute care settings, and she had been a nurse for [AGE] years. RN A said she was hired as a nursing supervisor and oriented with LPN A on a medication cart on Friday ([DATE]). They had 20 residents and she had never experienced that. A lot of the residents required a lot of care but did not get it because there were not enough staff. She felt unsafe right away. The second day she came in there were not enough nurses. She and an LPN had 60 residents and they were on the medication cart. She was given no administrative orientation. She did not know anyone's name, role, or facility guidelines. RN A did what she did in the hospital or would have done at home that day. She did what she was trained to do. She was the highest licensed position in the building but was expected to act in a supervisory role even though she was in orientation. When she entered Resident #1's room, he was supine with his oxygen tubing on the floor and the concentrator running. His bipap/cpap machine was on the bedside table. It was off and the mask was on the table. His hands, fingertips, lips, face and feet were blue, and the body was cold, rigid, and firm to the touch. RN A said she had pronounced hundreds of people. A lot! People responded to the Code

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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, facility reports, staff interviews, and the facility's policy and procedure titled Florida Cardiopulmonary Resuscitation (CPR), the facility failed to provide CPR for one resident who was a Full Code status (the desire to be resuscitated in the event of cardiac/respiratory arrest) after finding him unresponsive with no respirations. This affected one (Resident #1) of three residents reviewed for Advance Directives. The facility's failure to provide CPR according to Resident #1's Advance Directives deprived him of potentially lifesaving measures. Resident #1 was not revived and expired in the facility. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 1:34 p.m. on [DATE]. On [DATE], at 7:35 a.m., Immediate Jeopardy began. On [DATE], at 5:30 p.m., the Interim Administrator/Associate Regional [NAME] President of Operations (ARVPO) 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 failing to provide cardiopulmonary resuscitation (CPR) to a resident with a CPR order. The findings include: Cross Reference F578 A closed record review for Resident #1 found he was admitted to the facility from an acute care hospital on [DATE] for short-term skilled care, with an expected discharge home with his spouse. He had diagnoses including acute systolic congestive heart failure (the left ventricle cannot contract normally), chronic respiratory failure with hypercapnia (the body has too much carbon dioxide in the blood and cannot rid itself of the excess), acute pulmonary edema (fluid buildup in the lungs making it difficult to breathe), chronic obstructive pulmonary disease (COPD, lung disease causing restricted airflow and breathing problems), and atherosclerotic heart disease of the native coronary artery without angina pectoris (a buildup of plaque on the inner walls of the heart arteries, causing narrowing and blocking blood flow, without chest pain). A review of the Death in Facility Minimum Data Set (MDS) assessment with a reference date of [DATE], revealed that Resident #1 expired on [DATE]. A review of the resident's medical record revealed physician's orders dated [DATE] for Full Code Status and a plan to discharge home. (Photographic evidence obtained) A review of the medical record's nursing progress notes revealed the following: (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 10:04 a.m., Registered Nurse (RN) A/Weekend Supervisor (in training) charted that at approximately 7:35 a.m., a code (Code Blue - used to announce a resident is unresponsive) and 911 were called for Resident #1. RN A immediately responded and assessed the resident to be pulseless, apneic (involuntarily and temporarily stopped breathing), unresponsive, and cool to the touch. It was noted that CPR was performed for approximately 15 minutes. Code called by this RN. Calls placed to ADON (Assistant Director of Nursing) and DON (Director of Nursing). EMS (Emergency Medical Services) entered the building at approximately 8:15 a.m . at 8:20 a.m. as deceased (sentence incomplete). Call placed to wife. (Photographic evidence obtained) On [DATE] at 5:15 p.m., Licensed Practical Nurse (LPN) B noted that the CNA (Certified Nursing Assistant A) for Resident #1 entered his room and found the resident unresponsive. CNA A advised LPN B, who immediately checked the chart for a Do Not Resuscitate (DNR) status while the nurse on the 200 hall, LPN A, called the Code Blue and 911. The resident did not have a DNRO (do not resuscitate order). CPR was started and continued for five rounds, for approximately 15 minutes until 7:50 a.m. Patient's body was stiff and rigid. Cold to touch. Registered Nurse (RN) on duty notified the ADON and Administrator. Re-started CPR at 7:54 AM. EMS re-called; patient pronounced deceased 8:20 a.m. (Photographic evidence obtained) A review of a facility report generated by the Nursing Home Administrator (NHA) on [DATE] at 6:48 p.m. alleging neglect, declared that on [DATE] at approximately 7:35 a.m., Resident #1 was observed by CNA A to be unresponsive. CNA A notified LPN B, who immediately retrieved Resident #1's medical record and discovered the resident was a Full Code. LPN A verified the Full Code status, paged Code Blue on the overhead speaker and notified 911. LPN B went to the room and RN A arrived with the crash cart. RN A assessed the resident as cool to the touch, pulseless, and apneic. His digits were blue. CPR was immediately initiated and performed for approximately five rounds/15 minutes. RN A then stopped CPR to notify the NHA of the incident but was instructed to continue CPR. The CPR was stopped for approximately , d+[DATE] minutes, then resumed. EMS (emergency medical services) arrived at the facility and placed leads on the resident, who was found to be without a pulse. EMS pronounced the resident deceased at 8:20 a.m. An update to the report on [DATE] at 9:56 p.m. revealed that from [DATE] to [DATE] between the hours of 11:00 p.m. and 6:00 a.m., CNA B stated Resident #1 was seen at 11:00 p.m., then called for assistance at 12:30 a.m. and again at 3:00 a.m. At 6:00 a.m., the resident was noted to be sleeping in his bed. On [DATE] at 5:00 a.m., LPN F stated I was in there often throughout the night. He kept taking his CPAP off. His O2 (oxygen) sat (saturation) was ,d+[DATE]%, but he kept taking it off, and I kept redirecting him. At 5:00 a.m., I gave him meds (medications) and he was fine. He wasn't wearing the mask, but he was awake. (Photographic evidence obtained) As part of the facility's investigation, written statements from licensed staff on duty the morning of [DATE] were obtained. A review of the statements revealed the following: CNA A noted that she started passing drinks at 7:30 a.m. in room [ROOM NUMBER]. When she got to [Resident #1's] room, she tapped his foot, called his name and shook his arm, but got no response. She told LPN B he was not responding. By the time she got back to the room, RN A entered. CNA A waited outside until ordered by RN A to start post-mortem (after death) care. RN A noted that Resident #1 was pulseless, apneic, unresponsive, and cool to touch. CPR was performed for approximately 15 minutes. RN A called the code, and the ADON and DON were called immediately. EMS entered the building at approximately 8:15 a.m. and pronounced the patient deceased at 8:20 a.m. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a second written statement by RN A, also on [DATE], she added that Resident #1 was apneic, pulseless, cool to the touch, and with blue lips, fingers, toes and ears. CPR was performed per protocol and despite the RN's assessment, for approximately 15 minutes. Resident #1's oxygen was running but the nasal cannula was not on his face. RN A pronounced the resident deceased secondary to no life response. She turned EMS away the first time they arrived, as she was unaware that she was not permitted per facility protocol to pronounce a resident deceased . She dispatched EMS again, and they returned at 8:15 a.m. EMS assessed the resident as deceased and pronounced his death at 8:20 a.m. In a second written statement on this day by RN A, she added that she conducted CPR for 15 minutes, then pronounced the resident's death. LPN B wrote that CNA A advised her that Resident #1 was unresponsive. LPN B checked the chart while LPN A called 911. The resident did not have a Do Not Resuscitate Order (DNRO). CPR was started for five rounds for approximately 15 minutes until 7:50 a.m. The resident's body was stiff and cold to the touch. RN A notified the ADON and NHA. CPR was restarted at 7:54 a.m. EMS was called and pronounced the resident's death at 8:20 a.m. LPN A wrote that while passing medication on the 200 hall, the 500 hall nurse told her a CNA advised that Resident #1 was expired. She immediately ran to check the chart for the resident's code status, then called 911. While on the phone with 911, the nurse supervisor (RN A) came and told her she had it handled. LPN D wrote that when she responded to the hall for the Code Blue call, the RN supervisor told her she was not needed. LPN C noted that she heard the overhead page and ran to check the resident's chart, but they were already checking. Then the nurse supervisor stated they had it handled. The NHA noted that she called the county's Emergency Medical Services to request reports. She was advised that they were dispatched at 7:50 a.m. for CPR in progress but were made aware that the resident had rigor and the nurse had called it, so they left. They were called back 15 minutes later as CPR had been resumed, since they (the nurse) were unable to pronounce the resident's death. When EMS arrived, they placed two leads on the resident and pronounced him deceased at 8:20 a.m. LPN E wrote that she heard the Code Blue announced and walked toward 500 East. Her partner nurse was coming back and said, they don't need us. She then noticed the 911 truck and went to see what happened. The RN supervisor (RN A) was walking out of the room and told East Wing staff to cancel 911, he is already cold. (Photographic evidence of all statements obtained) On [DATE], additional statements from follow-up interviews were noted by the ADON and revealed the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN A explained that her new employee orientation Friday ([DATE]) was fast because the facility needed her. She got no training, just a stack of papers to sign, and then was sent with LPN A to shadow her on the medication cart. On Sunday ([DATE]), she heard the Code Blue called and responded, finding Resident #1 lifeless. She sent responding nurses away because there was nothing to code. No one wanted to take charge, and everyone was looking at her for what to do. She did the best she knew how to do. RN A said she had pronounced bodies 100 times. After turning EMS away, the other nurses told her she shouldn't have done that. RN A asked why not, pointing out the fact that the resident was expired. RN A left the room and texted the NHA, DON and ADON. When they arrived, everyone started taking statements. LPN B told RN A the NHA said they had to lie and say they did CPR, or they could lose their licenses. CPR was never done, not once. RN A said, I wouldn't do that to a dead body; you wouldn't want that done to your loved one. LPN B admitted everything she said in her previous statement was true but added that she was told by the NHA to say they did CPR, or she would lose her license. LPN B admitted they never performed CPR, as the resident had been dead for a long time. RN A pronounced his death and said it would be defiling a body to do CPR. LPN B wrote that EMS said the resident had to have been dead for two to three hours. RN A pronounced his death at around 7:48 a.m. LPN D explained that she was the 400 hall nurse and responded to the Code Blue overhead page. She went to the resident's room and RN A reported the patient died , nothing could be done, and LPN D wasn't needed. LPN D asked, Don't we have to do CPR? RN A advised, He's been dead for a while and there's nothing we can do. I pronounced him. LPN D returned to her unit. CNA C stated she heard the Code Blue and responded. There were five CNAs outside of the resident's door and two nurses were in the room; one was the RN supervisor (RN A). CNA C asked, Are we doing anything? No one responded. The RN supervisor came out of the room and said there was nothing they could do; he'd been gone too long. (Photographic evidence of all statements obtained) On [DATE], the Regional [NAME] President of Operations (RVPO) generated a follow-up facility report that included an analysis of the event and detailed the findings of the facility's investigation. In the summary of interviews conducted, the newly identified discrepancies from the original witness statements were noted. They were summarized as follows: LPN B now stated that on [DATE] at 7:30 a.m., after responding to the resident's room, the RN on duty was in the room and said the resident was expired, had been dead, and there was nothing to code. LPN B told the RN the resident was a full code. The RN said, There is nothing to code.; that (performing CPR) would be defiling a body. The RN directed the CNAs to start post-mortem care and stated she would notify everyone and had it handled. RN A heard a Code Blue called and ran to the resident's room. The resident's oxygen tubing was on the floor with the oxygen concentrator running. The resident was lying supine (on his back) with no pulse, no respirations, no response, stiff, cold to touch, lips, ears, fingers and feet were all blue. RN A applied a stethoscope for apical pulse; none was noted for one minute and still no respirations. RN A stayed in the room until EMS arrived for the first code. She stopped them to report the resident was deceased . Nurses were responding to the room, but RN A sent them away because there was nothing to code. CPR was never done, not once. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Photographic evidence of both statements obtained) The report's conclusion was that as a result of the investigation which had been conducted by the Regional Nurse Consultant (RNC), the allegation of neglect was substantiated. (Photographic evidence obtained) The facility's policy and procedure titled Florida Cardiopulmonary Resuscitation (CPR) (document N-301 effective [DATE], revised [DATE]) revealed: Policy: Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a fully executed Florida Do Not Resuscitate (DNR) order. Procedure: 1. In the event of cardiac arrest, immediately call for assistance. 2. Two licensed nurses are to verify: - Resident identification - Fully executed Florida Do Not Resuscitate order (DH1896), located in the advanced directive section of the medical record. 3. Use the paging system and call Code Blue to Room Number or location of the event three times. 4. In the absence of a fully executed Florida Do Not Resuscitate order (DH1896) the facility will immediately begin CPR. 5. Center staff will continue performing CPR until Emergency Medical Technicians assume responsibility for CPR, or it may be discontinued if: - The resident responds. (Photographic evidence obtained) An interview was conducted with the Director of Nursing (DON) on [DATE] at 3:05 p.m. She advised that she was not present the day of the event but said RN A was supposed to be in orientation. She chose to take herself off orientation and help out on the floor. Company policy when finding a resident unresponsive is to check the code status, call Code Blue, and perform CPR (if full code) until EMS arrives, even if there are apparent signs of death. EMS will put the leads on and make that call. Nurses are not allowed to pronounce residents' deaths. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with CNA A on [DATE] at 7:10 a.m., revealed that on [DATE], she was assigned to rooms 504 to 509 and began her shift with passing drinks. At approximately 7:30 a.m., upon arriving at room [ROOM NUMBER], she greeted Resident #1, but there was no response. He appeared to be sleeping, but when she lifted his hand it just dropped, and he felt cold. She alerted CNA D, who confirmed Resident #1 appeared deceased , and together they notified LPN B. When CNA A, CNA D, and LPN B arrived back at Resident #1's room, RN A was already there. LPN B announced that the resident was a full code, however RN A refused to perform CPR and ordered CNA A and CNA D to start post-mortem care. EMS was seen outside the door but was leaving without entering the room. While providing post-mortem care, RN A announced, CPR should've been performed and EMS allowed in. She then stood over Resident #1 and performed pretend CPR with hand movements over his body. EMS returned and were informed by the nursing staff that CPR was performed for three minutes, however, CPR was never performed. Later, CNA A reported she was approached by LPN B, who stated they needed to keep their stories straight, and say CPR was performed for three minutes. The NHA was interviewed on [DATE] at 11:25 a.m. She recalled being asleep that Sunday morning when RN A called her to report finding Resident #1 deceased . The NHA asked if the resident was a full code. When told, yes, she instructed RN A go start CPR now. When she arrived at the facility, she approached LPN B, the resident's assigned nurse, and asked what happened. LPN B did not respond. LPN B then said RN A stopped it. The NHA asked, What do you mean? This is your patient, right? LPN B then said the resident was deceased ; that she ran in and started CPR, then RN A called it and called the NHA. RN A went back into the room and re-started CPR. The NHA thought to herself, Ok, well at least CPR was done. The NHA started writing her facility report while the ADON interviewed staff, including LPN B and RN A. Those statements were all she had to write in the first report. Corporate then asked for the statements to be amended to include Resident #1 being cold, blue and rigorous when found. The following Monday ([DATE]), the ADON came to her and said the timeline wasn't adding up; that her gut was telling her the nurses were not telling the truth about starting CPR. The Regional Nurse Consultant (RNC) came in the next day and took over the investigation. The NHA never spoke with anyone else after that. On Wednesday, the RNC told her CPR was not, in fact, started. The NHA responded, What the f*** are you talking about? The RNC explained the CNA came forward and admitted LPN B had called them all together and told them they needed to have a plan and come up with a statement before the NHA and the ADON got to the facility. Then, LPN B and RN A stood over the body and pretended to perform CPR. LPN B then blamed the NHA for saying they had to come up with the false statement. That did not happen! The NHA explained that she thought, after reminding LPN B that Resident #1 was her resident and her responsibility, LPN B may have panicked and told this whole story about starting CPR. CNA A was the only one who told the truth about LPN B saying, We've got to come up with a statement, make up a story. I worked hard for that license. The RNC was interviewed on [DATE] at 12:00 p.m. After reiterating the findings in the facility reports as above, he stated the only thing they knew for sure was that CPR was not started. He called it a series of unfortunate events. The Medical Director (MD) was interviewed on [DATE] at 2:10 p.m. He said the NHA advised him of the situation on the day of the event. There was now a question about whether the CPR was performed. Resident #1 was diagnosed with COPD and CHF. His chances of recovery were minimal, but he was a full code. CPR should have been initiated. The nurse acted on her own. The MD stated a nurse like this could damage a building for years. It was a mistake by this nurse that affected the whole building. He said, This is a setback. It is so sad. (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 2:13 p.m., an interview with CNA D revealed that on [DATE], she was approached by CNA A regarding Resident #1. She went with CNA A to room [ROOM NUMBER] where she agreed that Resident #1 appeared deceased , and she notified LPN B. Upon returning to the room, RN A was already there, turning staff away telling them that he was gone already and she was calling it. LPN A, LPN C, LPN E and RN A began arguing back and forth because the resident was a full code. No one initiated CPR. RN A initiated not real CPR while LPN A, LPN B, LPN C and LPN E stood watching at the door. CNA D again stated, CPR was never initiated for [Resident #1]. When the Administrator arrived, she was pressuring CNA D for a statement while the ADON tried to come up with a story to cover things up. LPN C was interviewed on [DATE] at 3:09 p.m. She stated when she responded to the Code Blue call for Resident #1, the supervisor lady (RN A) was in the room with her phone in hand. Lots of people were at the door. The supervisor (RN A) said, Don't worry about it, we got it. An interview conducted on [DATE] at approximately 3:15 p.m. with CNA C revealed that on [DATE], she responded to a Code Blue call for room [ROOM NUMBER]. Upon arrival, she observed multiple nurses and CNAs in the room, but nothing was being done. CNA C asked if anyone was going to do anything because the resident was a full code, but she was informed by RN A that there was nothing they could do. EMS showed up but got turned away by RN A before seeing Resident #1. LPN G was interviewed on [DATE] at 3:25 p.m. She stated the facility protocol when finding anyone unresponsive was to first check the resident's chart to see if a DNRO was in place. Two nurses must verify the code status for anyone discovered with cardiac/respiratory arrest. If the resident was a full code, staff were to start chest compressions. Someone grabbed the crash cart and called 911. Even in the presence of obvious signs of death, CPR was to be initiated. CPR could never be stopped until medics or a doctor arrived. She was not, as a nurse, permitted to pronounce anyone's death. RN B/Unit Manager was interviewed on [DATE] at 3:32 p.m. The facility policy if a resident codes is to get help. Two nurses check the chart and if a full code, someone calls 911, and someone gets the crash cart. Don't stop CPR until paramedics get there and take over or pronounce. You are absolutely not allowed to pronounce a resident death as a nurse. Even with obvious signs of death, if the resident is a full code, CPR is started. During the survey, the facility volunteered its Quality Assurance Performance Improvement (QAPI) plan and Performance Improvement Plan (PIP) developed in response to the incident. The plan was reviewed with the RVPO, ARVPO, DON and RNC on [DATE] at 4:30 p.m. The DON explained that the QAPI committee met monthly and included the Medical Director and all department heads. Departmental surveillance and data were used to identify trends that might need improvement plans. Floor staff, resident grievances and resident council meetings were also used to identify concerns. Once identified, concerns were delegated to appropriate departments and a performance improvement plan (PIP) was developed. Depending on the issue, the situation was monitored until compliance was achieved, preferably total compliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105952	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Grand Oaks	3001 Palm Coast Parkway SE Palm Coast, FL 32137

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The RNC contributed, explaining that following the incident, an Ad Hoc QAPI meeting was conducted on [DATE] and the PIP was developed. The data was gathered, and a root cause analysis was determined. Initially, the root cause analysis focused on a lack of orientation training for RN A, the new supervisor. This was the primary focus. RN A was oriented on Friday and was supposed to be orienting that Sunday but ran off on her own. That is where they felt maybe they could have done something differently. In response, all resident code statuses were checked and found to be accurate. The initiation of the Code Blue response the day of the incident was also deemed correct. But then, the false information presented and forced a revisit. Another Ad Hoc QAPI meeting was conducted on [DATE] with the discovery of false information. False documentation was also identified. A separate plan was developed to focus on ethics and compliance; how to now address unethical behavior and staff response. Being the only RN in the building on the day of the event, staff felt it would be insubordination to reject her directives. They were re-educated on that. Staff were trained on Advance Directives (AD), and they made sure all licensed staff were aware of what that meant, as well as the situations during which Advance Directives should be honored. Staff were trained in the facility's CPR policy, including when to start CPR. An audit of CPR certifications for nurses was performed and now all nurses were American Heart Association (AHA) certified. Abuse and neglect training was provided building wide. Scheduled deviations were covered too, since RN A had effectively removed herself from facility orientation. The ARVPO added the focus was currently on policing themselves and resulted in another root cause analysis and evaluation of processes. The second QAPI was conducted about the corporate compliance program with a focus on staff notification (of non-compliance) and filing concerns without fear of retaliation. It also included what to do if someone asked a staff member to do something unethical. Code blue drills were still being conducted with all licensed staff participating. Staff had been retrained, or received the information packet, on Code Blue response and drills. There was a QAPI meeting scheduled for tomorrow ([DATE]), and the PIP would be re-evaluated. Weekly Advance Directive audits were being conducted, and the facility would continue reviewing nurses' CPR status and licensure. This was all added to the orientation process. Classroom training for new nurses would be audited to ensure completion. CPR tests were provided to validate the nurses' understanding of policies with 100% of nurses passing. On [DATE] at 1:03 p.m., LPN B was interviewed and explained that on the day of the event, RN A was training with her. The CNA came and told her that Resident #1 was deceased and stiff. One nurse called the Code Blue, and someone called EMS. LPN B went to the room after RN A ran in. The resident was in full 100% rigor, stiff as a board, and had been dead for a while. RN A decided there was nothing they could do. Nothing would have brought him back; they would have broken all the bones in his body (had they initiated CPR). It was too late. LPN B admitted they did not perform CPR. She told RN A that facility protocol was to provide CPR. RN A called the NHA who instructed her to call medics and get back in the room and perform CPR. It had been 30 minutes since they had discovered the body at this point. The NHA was more concerned about what was going to happen to the facility and wanted RN A to lie. When the NHA arrived at the facility that day, she told LPN B, You know, this could affect your license. She threatened LPN B that she would lose her nursing license. The NHA insinuated that they had to lie and was asking pointed questions such as, This happened, right? LPN B said she felt cornered and threatened, as though she had no choice but to do what the NHA wanted her to do. Then the NHA would not let LPN B leave until she went over her documentation to make sure it included everything the NHA wanted it to include. She stated again that no one ever started CPR. The resident was in full rigor. When EMS came back, they said he had been dead for at least three hours. LPN B told the truth when she talked to the RNC. She stated, Was it wrong for me to document what I did? Yes, it was. LPN B concluded, saying she was afraid not to follow the NHA's instructions. (continued on next page)

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