STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106065	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isle Healthcare & Rehabilitation Center	1125 Fleming Plantation Blvd Orange Park, FL 32003

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38804 Based on resident and staff interviews, record review, and a review of facility policies and procedures, the facility failed to ensure that individual financial records were available through quarterly statements and upon request for 56 of 56 residents with personal funds accounts in the facility. Quarterly statements were not provided to the residents since at least May 2024. The findings include: During an interview with Resident #1 on 3/14/25 at 12:13 p.m., she stated she did not know what her personal funds account balance was, and she was unaware that the facility was to provide her with statements of her account. A review of Resident #1's medical record revealed an admitted [DATE]. A review of the resident's quarterly Minimum Data Set (MDS) assessment, dated 12/11/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. She was documented with adequate vision and hearing, clear speech, she was understood, and she understood others. On 3/14/25 at 12:24 p.m., the Business Office Manager (BOM) was asked for a list of residents with personal funds accounts. At 1:35 p.m. a list was received and reviewed, revealing that as of 3/14/25, there were 56 residents in the facility who had personal funds accounts. Six of 56 resident accounts had balances exceeding $2000.00, which is the Social Security Income (SSI) resource limit for Medicaid eligibility in Florida (continued on next page)

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

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/14/25 at 1:35 p.m., an interview was conducted with the BOM. She stated she had been the BOM at the facility since May 2024 and the Assistant BOM from 2023 through May 2024. She further stated she was responsible for maintaining the residents' accounts. The statements were to be provided to the residents quarterly but had not been provided since she had become the BOM in May 2024. The facility utilized a third-party billing company who assisted with the statements. The BOM stated resident accounts were monitored by the facility's Regional BOM and the third-party billing company. When asked, the BOM stated she was unsure of how residents were notified of times they could access their funds. She stated none of the residents with more than $2000.00 in their accounts had been notified of their balances. (If residents exceed their SSI resource limit, they may lose their eligibilityfor Medicaid or SSI.) She and the Regional BOM were working together to reconcile resident accounts so that all balances matched and residents with accounts received notices. She did not provide a timeframe for when the process started or a possible resolution date. On 3/14/25 at 4:29 p.m., an interview was conducted with the Regional BOM. She confirmed that residents had not been receiving their quarterly account statements and stated, They haven't gotten them, but they will. It's a part of what we've been working on. Residents will begin to receive letters when they get close to $2000.00 in their accounts. The facility's policy: Resident Trust Fund Notification Authorization and Beneficiary Designation (Undated) was reviewed and revealed: The resident may see records of his/her account through quarterly statements and upon request. (Photographic evidence obtained)

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 38804 Based on resident and staff interviews and record review, the facility failed to notify each resident that received Medicaid benefits when the amount in the resident's account reached $200.00 less than the Social Security Income (SSI) resource limit for one person; and that if the amount in the account, in addition to the value of the resident's other nonexempt resources, reached the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This affected six of 56 residents with personal funds accounts in the facility. The findings include: During an interview with Resident #1 on 3/14/25 at 12:13 p.m., she stated she did not know what her personal funds account balance was, and she was unaware that the facility was to provide her with statements of her account. On 3/14/25 at 12:24 p.m., the Business Office Manager (BOM) was asked for a list of residents with personal funds accounts. At 1:35 p.m. a list was received and reviewed, revealing that as of 3/14/25, there were 56 residents in the facility who had personal funds accounts. Six of 56 resident accounts had balances exceeding $2000.00, which is the Social Security Income (SSI) resource limit for Medicaid eligibility in Florida On 3/14/25 at 1:35 p.m., an interview was conducted with the BOM. She stated she had been the BOM at the facility since May 2024 and the Assistant BOM from 2023 through May 2024. She further stated she was responsible for maintaining the residents' accounts, and none of the residents with more than $2000.00 in their accounts had been notified of their balances. She and the Regional BOM were working together to reconcile resident accounts so that all balances matched and residents with accounts received notices. She did not provide a timeframe for when the process started or a possible resolution date. On 3/14/25 at 4:29 p.m., an interview was conducted with the Regional BOM. She stated, Residents will begin to receive letters when they get close to $2000.00 in their accounts.

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident records, the facility's standards and guidelines, facility reports, hospital records, and interviews with staff, the facility failed to act in accordance with a resident's advance directives in accordance with her Do Not Resuscitate (DNR) status (the desire have cardiopulmonary resuscitation (CPR) withheld in the event of cardiac or respiratory arrest) after finding her unresponsive. This affected one (Resident #2) of four residents reviewed for advance directives. The facility's failure to review and honor Resident #2's DNR status prolonged her dying process, deprived her of a natural death, and likely resulted in severe pain and organ damage. Additionally, Resident #2 could not express her reaction to this event. Applying the reasonable person concept, Resident #2 would likely experience serious psychosocial harm by being resuscitated against her wishes. Resident #2 died at the hospital after removal of life support. Immediate Jeopardy (IJ) at a scope and severity of J (isolated) was identified at 3:35 p.m. on [DATE]. On February 20, 2025 at 6:17 a.m., Immediate Jeopardy began. On [DATE] at 4:50 p.m., the Administrator was notified of the IJ determination, and Immediate Jeopardy was ongoing as of the survey exit on [DATE]. The findings include: A closed electronic medical record (EMR) review revealed that Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE]. She had diagnoses including alcohol dependency with withdrawal delirium (a potentially life-threatening condition after someone suddenly stops drinking alcohol, and resulting in confusion or hallucinations), and unspecified encephalopathy (a disorder of the brain that can cause confusion, disorientation and memory loss). A Discharge/Return Not Anticipated minimum data set (MDS) assessment, dated [DATE], revealed that Resident #2 had modified independence with daily decision making. She was dependent on staff for activities of daily living. Additional diagnoses included urinary tract infection, malnutrition, psychotic disorder, melena (black tarry stools as a result of bleeding in the upper gastrointestinal tract) and fatty liver. She had no condition or chronic disease that might result in a life expectancy of less than six months. Discharge planning was not occurring. Resident #2 was care planned on [DATE] for Advance Directives (AD)/Do not Resuscitate. Goal: If Resident #2's heart stopped or if she stopped breathing, CPR would not be initiated in honor of her DNR wishes, ongoing, through the next review date. Interventions included: Advise resident/representative to provide copies of any updated AD. Allow resident to discuss feelings about their AD. Advance Directives can be revoked or changed if the resident or representative changes their mind about the medical care they want delivered. Discuss AD with resident and/or appointed health care representative. For DNR status: Verify presence of physician's order for DNR. Notify physician of resident's wishes regarding life-prolonging procedures. Resident is DNR . (Photographic evidence obtained) (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2 had a physician's order dated [DATE] for Advance Directive: DNR. She had a corresponding yellow DNR form (DH 1896) that was signed by her friend/health care surrogate/proxy and the physician on [DATE]. The form was scanned into the electronic medical record on the day of execution, [DATE]. (Photographic evidence obtained) A physician's progress note dated [DATE] revealed that Resident #2 had chronic diastolic heart failure (the heart's left ventricle becomes stiff, resulting in reduced blood flow), hypertension, weakness, hepatic steatosis (fatty liver), polysubstance abuse, anxiety/depression and a thoracic vertebral fracture (cracking or breaking of bone). The practitioner noted that Unfortunately, this patient continues to decline. Family has requested a hospice consult. (Photographic evidence obtained) A nursing progress note authored by Registered Nurse (RN) A and dated [DATE] at 7:00 a.m., revealed that during medication administration, Resident #2 was found unresponsive around 6:15 a.m. She had been checked 20 to 30 minutes prior and was breathing and responsive. Once the resident was found unresponsive by RN A, a Code Blue (a universal term that signifies a medical emergency, specifically a cardiopulmonary arrest (cardiac or respiratory arrest), requiring immediate and comprehensive medical intervention) was called on the overhead speaker system. Emergency Medical Services (EMS) was called by RN A. The resident's chart was reviewed by RN A and a Full Code status was noted. The cart (crash cart - a rolling cart with drawers used for transporting life support equipment to the site of an emergency) was outside the resident's door when her status was checked, and CPR was initiated by staff members. Paperwork was gathered by RN A and then handed off to EMS by Licensed Practical Nurse (LPN) B. EMS arrived within a few minutes, then took over Resident #2's care. She was transferred via EMS to the hospital. (Photographic evidence obtained) RN A authored a follow-up nursing progress note on [DATE] at 7:15 a.m. It indicated that the hospital called RN A about Resident #2's code status and made her aware that the resident's status was DNR. It was then double-checked by RN A who discovered that Resident #2 did, in fact, have a DNR status. The Unit Manager was notified. A final nursing progress note, dated [DATE] at 4:04 p.m., revealed that Resident #2's friend came to pick up her personal belongings and notified the staff that Resident #2 had passed away with the chaplain and herself present. (Photographic evidence obtained) (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of facility documentation revealed that on [DATE], the Director of Nursing Services (DNS) authored a report, which noted that on admission, Resident #2 was a Full Code status. On [DATE], Resident #2 was deemed incapacitated, and a friend became her Health Care Surrogate (HCS). The HCS signed the DNR, and an order was received from the doctor to change her code status to DNR on [DATE]. On [DATE] at approximately 5:45 a.m., RN A went into Resident #2's room and noted that she was responsive and breathing. Then at 6:15 a.m., she reentered the room for medication administration and found the resident unresponsive. RN A notified staff, Code Blue was paged overhead, and EMS was called. The resident's code status was checked by RN A, and she indicated to the other nurses that Resident #2 was a Full Code. The nurses then began CPR and RN A went to print paperwork for EMS. EMS arrived within a few minutes, and they took over the care. At 7:15 a.m., the hospital called and spoke to RN A to inform her that Resident #2 was a DNR. RN A double-checked the medical record and realized that the resident was indeed, a DNR. She immediately notified the Unit Manager (UM), who notified the DNS. The DNS arrived at the facility and notified the Executive Director at 7:50 a.m. At 8:15 a.m., the UM notified the Doctor and the HCS of the events. Later that afternoon, the HCS came to the facility to pick up the resident's belongings and informed staff that Resident #2 had passed away in their church Chaplain's presence. After a complete and thorough investigation, the facility did find a deviation of practice by RN A. An interview was conducted with Certified Nursing Assistant (CNA) E on [DATE] at 1:10 p.m. She stated she had worked in the facility since [DATE] and recently received training in Code Blue responses. She stated if she found a resident unresponsive, she would let the nurse know and call Code Blue three times overhead with the location or room number. CNAs were not permitted to do CPR but could check the code status with a nurse. Code status for all residents could be found in the electronic medical records (EMR) or in the DNR book, which was behind each nurses' station. CNA E pulled up an unsampled resident's electronic Point of Care where the CNAs documented daily on each shift. The resident's code status was prominently displayed on the EMR's dashboard. CNA E explained that you must know the resident's code status before performing CPR. Even if the electronic records and internet were down, You go get the book. Licensed Practical Nurse (LPN) F stated in an interview on [DATE] at 1:20 p.m. that Advance Directives were obtained for each resident on admission. If a resident had a DNR, they requested the yellow DNR form. Additional yellow copies were made for the east and west wing DNR books, and one copy went to medical records to be scanned into the EMR. As soon as the order was entered, the code status would populate on the EMR dashboard for all to see. An interview was conducted with the DNS on [DATE] at 4:05 p.m. He explained that on the day of the event, RN A went into Resident #2's room and found her responsive. She returned to the room for medications 20 to 30 minutes later, and the resident was unresponsive. RN A called a code blue, looked in the chart and said she thought she read Full Code. The order for the code status was highlighted in a gray bar at the top of the EMR dashboard. RN A didn't explain how, just that she swore she saw Full Code. LPNs B and C went into the resident's room and initiated CPR. RN A called 911 and got the paperwork ready for the EMTs, who arrived quickly, took over and transported the resident to the hospital. RN A received a phone call from the hospital around 7:15 a.m. informing her that You realize this resident was a DNR. RN A reviewed the computer and verified that, indeed, was the order. She was pretty upset. At the time, one nurse was permitted to verify the code status. The HCS came and picked up Resident #2's belongings and advised staff that the resident had passed away the same day in the hospital. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's standard and guideline titled Advance Directives (Implemented [DATE], Reviewed/Revised [DATE]), revealed: Standard: It will be the standard of this facility that the resident has the right to request, refuse, and/or discontinue treatment . and to formulate an advance directive and participate in advance care planning. Advance Directives/Advance Care Planning designations will be respected in accordance with state law and facility policy. Definitions: . Advance Directive means, according to 42 C.F.R. $489, 100, a written instruction, such as a healthcare surrogate, living will, Do Not Resuscitate and/or durable power of attorney for healthcare and/or financial decisions. Recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Some States also recognize documented oral instruction . 1. Prior to or upon admission of a resident to the facility, the Admission Department, Social Services, or designee will provide written information in a manner easily understood by the resident or resident representative about the right to refuse medical or surgical treatment and formulate an advanced directive . Staff will assist residents or resident representatives if they wish to formulate advance directives. . 5. Facility staff will provide assistance, if needed, if the resident/responsible party wishes to execute one or more directives. Facility staff will document in the medical record these discussions and any advance directives that the resident executes . . 13. Facility staff will identify, clarify, and periodically review, as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. . 14. Facility staff will identify situations where health care decision-making is needed, such as a significant decline or improvement in the resident's condition. 15. Facility staff will document and communicate the resident's choices to the interdisciplinary team and to staff responsible for the resident's care . . 18. In the event that the resident does not have previously developed advance directives or declines to create and participate in development of advance directives/advance care planning, the resident will be considered a full code until validation of the resident/representative wishes otherwise. 19. The Director of Nursing Services, Social Services, members of the nursing staff, or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. 20. The Nurse or Nurse Supervisor should inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made. (Photographic evidence obtained) A review of the facility Standards and Guidelines (S and G) for Code Blue and CPR (Implemented [DATE], reviewed/revised [DATE] and [DATE]) revealed: (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Standard: This facility will honor the resident/resident representative wishes regarding either the provision or withholding of cardiopulmonary resuscitation (CPR) . in accordance with related physician's orders, such as DNRs, and the resident's advance directives. In the event that a resident experiences cardiac arrest (cessation of pulse and/or respirations), CPR will be provided in the absence of a valid physician's order for Do Not Resuscitate (DNR), a State of Florida DNR Order Form (DH 1896), or documented verbal wishes indicating otherwise, which are pending physician order . Definitions: . Cardiopulmonary resuscitation (CPR) refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased . . Do Not Resuscitate (DNR) Order refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. Existence of an advance directive does not imply that a resident has a DNR order. The medical record should show evidence of documented discussions leading to a DNR order. Guideline: If a resident is found unresponsive, begin evaluation to determine presence or absence of pulse and/or respirations. In the absence of pulse and/or respirations do the following: 1. Remain calm. Remain with the resident. 2. Call out for help. 3. Licensed Nurse will assume command of the scene and will direct other personnel in the effort. 4. Direct a staff member to announce the emergency per facility protocol (i.e. Code Blue & Room Number three times) and direct staff to bring Emergency Equipment Cart and AED Machine (automated external defibrillator, a portable device used to treat sudden cardiac arrest) to the scene. 5. A staff member other than the one who is evaluating the resident and preparing to provide emergency care must promptly check current code status by checking the code status section of the EHR (electronic health record), eMAR (electronic medication administration record) or point of care kiosk . 6. (*In the event the EHR is unavailable, code status may by validated using a secondary check of the code binder via presence of physician order and/or a signed State of Florida Do Not Resuscitate Order (DH form 1896), and/or documented verbal wishes of resident/resident representative indicating code status preference. A telephone order of DNR status is validated and/or if obvious clinical signs of irreversible death as defined by the AHA (American Heart Association) are present, do not initiate CPR. If CPR/Code Status is undefined (absence of DNR, Advance Directive, documented verbal wishes of resident /representative or physician order), CPR will be initiated and will continue until the arrival of EMS or until discovery of a valid DNR (Do Not Resuscitate). (Photographic evidence obtained) (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of hospital records for Resident #2's admission on [DATE], revealed that on [DATE], Resident #2 was transported to the emergency department (ED) by EMS. She had already been intubated (a tube placed into the mouth or nose then down into the trachea/windpipe to keep the airway open) by the emergency medical technicians (EMTs) and received CPR. She had also been defibrillated (the delivery of an electrical current to stop the heart from beating irregularly and start a normal rhythm). Resident #2 was unresponsive, on a mechanical ventilator (a device that assists or replaces breathing for a person who is unable to breathe adequately on their own) and Norepinephrine (a drug that increases the heart rate, blood pressure and breathing rate), and intravenous fluids were administered as well as the antibiotic, Cefepime. Resident #2's heart rate was noted with regular rhythm with tachycardia (a rapid heart rate that is not proportionate to movement or activity), and there was decreased air movement. The principal problems included dyspnea (shortness of breath), acute, severe, uncontrolled, and worsening secondary to cardiac arrest. Her prognosis was grim. The record indicated that Resident #2 had a return of spontaneous circulation after CPR was administered, then went back into V-tach (a problem with the heart's electrical impulses that results in the lower chambers of the heart beating rapidly). She was defibrillated (the delivery of an electrical current to stop the heart from beating irregularly and start a normal rhythm) once and received two doses of Epinephrine (Adrenalin, a medication that acts as part of the body's fight-or-flight response to stress). While in the ED, the HCS was called and reported to the hospital staff that Resident #2 was a DNR; the forms were at the nursing home and signed two days ago. The hospital staff called the nursing home and they condirmed that they had the forms. The plan was to get Resident #2 into the intensive care unit and begin comfort measures (alleviating suffering in patients nearing the end of life). She was extubated (the breathing tube was removed) at 2:22 p. m. and passed away at 2:40 p.m. (Photographic evidence obtained)