

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 95036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF WEST PALM BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401		
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N 201 SS=J	<p>400.022(1)(i), FS Right to Adequate and Appropriate Health Care</p> <p>(i) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review, interview, policy review, and surveillance camera review, the facility failed to ensure a resident's advance directive choices were honored for a resident's expressed wishes for a () order for 1 of 4 sampled residents reviewed for status (Resident #1).</p> <p>The deficient practice caused Resident #1 to have likely suffered serious , harm by the facility's attempt to be against his wishes. Resident #1 could not express his reaction to this event; therefore, the reasonable person concept was applied. Additionally, there was a likelihood that Resident #1 experienced severe physical ; broken ; broken and in the area from the efforts</p> <p>(https://pubmed.ncbi.nlm.nih.gov/38206442/). The facility staff did not follow their procedure to verify code status prior to initiating .</p> <p>These actions resulted in the identification of Immediate Jeopardy. The facility administrator was informed of the Immediate Jeopardy on at 9:45 AM. The Immediate Jeopardy was removed after verification of the facility's</p>	N 201	<p>Resident # 1 was transferred to Good Samaritan Hospital and was pronounced at 5:51AM in the ER by Hospital personnel. No further corrective action could be taken</p> <p>An audit was completed on of current residents by the Unit Managers to ensure that residents with a have Form 1896 with appropriate signatures and date in their medical record and a copy in a red binder located at each nurses station. Irregularities were immediately corrected.</p> <p>Code status for new admissions and re-admissions will be reviewed daily Monday to Friday in AM clinical meeting by the Inter Disciplinary Team and on weekends by the Nursing Supervisor to ensure medical records reflect accurate code status and a copy of Form 1896 that is appropriately signed and dated is uploaded in the EHR and a copy is in the</p>	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Electronically Signed

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N 201	<p>Continued From page 1</p> <p>removal plan on _____, with an effective date of _____. The scope and severity was reduced to "D", no actual harm with potential for more than minimum harm.</p> <p>At the time of the investigation, there were 63 residents who were identified as _____ status.</p> <p>The findings included:</p> <p>A review of the facility's policy titled Advanced Directives and Code Status, dated _____ and _____, revealed the code status order will be documented in the electronic record and will serve as the primary source of validation of code status by a licensed nurse should a resident be found unresponsive. If the electronic record has an order for _____, then _____ will not be initiated. If the electronic record is down, the code status must be verified by a licensed nurse using the backup code status notebook. The State of Florida _____ form will be used to communicate a resident's _____ code status wishes to 911/Emergency Medical Services (_____) should the resident be found unresponsive.</p> <p>Record review revealed Resident #1 was admitted to the facility on _____, with diagnoses that included _____ of the _____, (_____), Type 2 _____, _____, and _____ . A comprehensive assessment dated _____ documented the resident was _____ and required substantial/ _____ with activities of daily living.</p> <p>Resident #1 was care planned for a _____ on _____. An intervention included to verify the presence of physician order for a _____.</p>	N 201	<p>binder at the nurses station if there is a order present</p> <p>An audit of crash carts located on each nurses station was completed on _____ by the Director of Clinical Services to ensure equipment was readily available in an emergency.</p> <p>An audit was completed on _____ by the HR Manager to ensure that current Licensed Nurses have a valid _____ license in place, one nurse had no current _____ on file but has since been completed on _____.</p> <p>Newly hired Licensed Nurses _____ cards will be verified during the Orientation process.</p> <p>Current Team members were reeducated started on _____ by the Director of Education and/or Designee on Code status, _____ policy, _____, and neglect and validation of code status in PCC.</p> <p>100% compliance was achieved on _____ . License Nurses Education to include _____ policy and procedure written post quiz on code status and code procedures for all licensed nurses, checking code status in PCC by a Licensed nurse if a resident was discovered to be pulseless prior to initiating _____. Attestations were signed for acknowledgement and understanding of policy.</p>	
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N 201

Continued From page 2

The resident had an order for date .

Resident #1's form/document was signed on by the resident. The document was signed by the physician, but not dated.

A review of Resident #1's progress notes, written by Staff Nurse A, a Licensed Practical Nurse (LPN), dated at 5:30 AM, revealed Resident #1 became unresponsive while care was being provided by Staff B, a Certified Nursing Assistant (CNA) and Staff C, a Certified Nursing Assistant (CNA). Staff Nurse A went to the room and the resident was difficult to arouse. Staff Nurse A, checked the computer for the code status, which was a . Staff A then proceeded to check the status binder for a signed yellow document, which was not in the binder. Staff Nurse A returned to the room, tried to arouse the resident again without success, and called 911. There was no documentation in the progress note on whether or not the nurse assessed the resident for a , or or that she had initiated . The progress note state the resident was transferred to the hospital for further evaluation and treatment.

During an interview with the Director of Nursing (DON) on at 11:30 AM. The DON acknowledged Resident #1 had a () and a signed document.

During an interview with the Unit Manager (UM) on at 1:20 PM. The UM stated she received a call on at approximately 5:55 AM from Staff A, who stated Resident #1 was being dressed for . and stopped talking. The resident was not responding. The UM asked

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New hires will be educated on the policy during the orientation process by the Director of Education/designee, with written post quiz to ensure competency.

Enhanced Code blue drills were conducted started on on the shift, every shift x 7 days, then every other day on different shift x 7 days, then weekly x 7 then one on each shift monthly to include weekends by the Director of Education and/or designee. Re-education post drills as needed.

Code Blue Drills will continue monthly by the Director of Education/designee one on each shift to include weekends and holidays. Results will be presented at monthly QAPI meetings to ensure ongoing compliance.

The Social Service Director/designee will continue weekly audits of orders to ensure that orders are accurate, and that Form 1896 is appropriately signed and dated and is in place in the EHR, and a copy is in the red binder at the nurses station in the event of a PCC or power outage.

New hires will be educated on the centers policy during the Orientation process by the Director or Education or designee with written post quiz and attestations to ensure competency.

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N 201	<p>Continued From page 3</p> <p>for the code status of the resident, and was told the resident was a _____ and had been sent out. The UM stated she called the nurse _____ and asked if she did _____, and nurse stated "yes". Then the UM called the Director of Nursing (DON) to inform her of the incident. The UM stated when she came in the facility, Resident #1 did not have a _____ form/document in the "Red book/ _____ status binder". The UM stated, she printed out the form and placed it in the binder. The UM stated, residents should have a _____ form in the binder for when residents transfer out, or in the case of a power outage.</p> <p>A telephone interview was conducted with the Risk Manager (RM) via telephone on _____ at 2:30 PM. The RM stated, he was notified via telephone that Resident #1 was sent out via 911 on _____. The RM stated, he started a chart review and spoke to staff about what occurred. The RM reviewed the surveillance cameras, and interviewed Staff A, Staff B, and Staff C, who all provided written statements. The RM stated, the root cause analysis was human error. The RM stated, Staff A knew Resident #1 had an order for a _____ in the electronic records, but second guessed herself and looked in the _____ status binder. The RM further stated that Staff A stated she did _____ on the resident.</p> <p>During an interview on _____ at 4:00 PM with Staff Nurse A, LPN, Staff Nurse A explained that 10 minutes prior to the incident, Resident #1 was getting ready for _____ and being helped by two CNAs, Staff B and Staff C. When she got notified of the resident being unresponsive, she was shocked, ran to the room, shook him and called his name, and there was no response. Staff A stated she went _____ to the nursing station, checked the _____ Status binder and did _____</p>	N 201	Results of audits will be presented at the Monthly QAPI meeting to ensure ongoing compliance.	
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N 201	<p>Continued From page 4</p> <p>not find the document. Staff A stated she called 911 and the operator said to start . Staff A stated she got the crash cart and went to the resident's room, a few seconds later arrived. Staff A stated, "there was no time for me to perform " " was started by " . Staff A stated that in the 8 years that she had been working in this facility, she was always told that the confirmation of a status relied on the yellow document in the binder on each unit. If no document was found in the binder, the resident should be treated like a full code. But they changed management so many times. Staff A stated she did not tell the 911 operator or that the resident had a order because they did not ask.</p> <p>There was conflicting information from Staff Nurse A's interview with the surveyors. Staff A stated to the surveyors that she did not initiate prior to arriving. However, a review of the report, dated 05:24 AM, stated upon their arrival Rescue found patient lying supine in a hospital bed with in progress. On , the DON provided a copy of the Advance Directive Acknowledgment form signed by Staff Nurse A, dated , which demonstrated Staff Nurse A had read and understood the facility's Advance Directive policy, which stated that the primary source to verify code status is the order in the electronic health record in PCC (Point Click Care).</p> <p>During an interview with the Social Service Director (SSD) on at 5:00 PM. The SSD stated her department is responsible for placing documents in the chart and binder. Before the document is placed in the status binder, it has to be signed and dated by resident/representative and physician. The</p>	N 201		
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N 201	<p>Continued From page 5</p> <p>document is placed in the binder and scanned into the electronic medical record (EMR) within the same day. The SSD stated she probably took the resident's document from the binder, scanned it into EMR, and did not replace it into the binder. The SSD stated it is an expectation that every resident that has a order has a document in the status binder.</p> <p>On the surveyors reviewed the surveillance footage which showed the paramedics wheeling Resident #1 down the hallway of the facility with the machine operating and ambu bag for (the full form of AMBU is Manual Breathing Unit. This device is used to provide positive pressure to patients who are not breathing or not breathing adequately).</p> <p>A review of the hospital emergency department admission record, dated at 5:47 AM, revealed Resident #1 was admitted while receiving . The hospital emergency department notes documented was called for patient unresponsiveness, the call was placed approximately 10 minutes prior to their arrival. There was no on their arrival. At the time of the patient arrival in the Emergency Department, there had been no for at least 30 minutes.</p> <p>A telephone interview was conducted with the Medical Director on at 11:00 AM. He acknowledged the above information.</p> <p>Class I</p>	N 201		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey, complaint number 2025005058, was conducted on _____ at Palm Garden of West Palm Beach. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>This is a 175-bed facility with a census of 167 residents on _____.</p> <p>On _____, a determination was made that the findings of the survey posed Immediate Jeopardy to the health and safety of residents who had executed _____ () orders at the facility. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements has caused, or is likely to cause serious injury, harm or _____ to a resident receiving care in the facility.</p> <p>Immediate Jeopardy (IJ) was identified at F578, 483.10(c)(6), Resident Rights to Request/Refuse/Discontinue Treatment; Formulate Advance Directives.</p> <p>On _____, at approximately 5:15 AM, the facility failed to ensure a resident's advance directive choices were honored, and the physician's order followed related to withholding _____ (), for a resident with a _____ () order for Resident #1.</p> <p>The facility's Administrator was notified of and provided the IJ Template on _____ at 9:45 AM.</p> <p>The Immediate Jeopardy was removed effective _____.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

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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.

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F 000	Continued From page 1 The scope and severity were reduced to a "D", no actual harm, with a potential for no more than minimal harm, due to the facility's failure to ensure a resident's advance directive choices were honored, and the physician's order followed related to withholding _____ (), for a resident with a _____ () status. The census at the time of the survey was 167. There were 63 residents with _____ status.	F 000		
F 578 SS-J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		

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F 578	<p>Continued From page 2</p> <p>entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>() If an adult individual is _____ at the time of admission and is unable to receive information or _____ whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its _____ to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, policy review, and surveillance camera review, the facility failed to ensure a resident's advance directive choices were honored for a resident's expressed wishes for a _____ () order for 1 of 4 sampled residents reviewed for _____ status (Resident #1).</p> <p>The deficient practice caused Resident #1 to have likely suffered serious _____ harm by the facility's attempt to be _____ against his wishes. Resident #1 could not express his reaction to this event; therefore, the reasonable person concept was applied. Additionally, there was a likelihood that Resident #1 experienced severe physical _____; broken _____; broken _____ and _____ in the _____ area from the _____ efforts</p> <p>(https://pubmed.ncbi.nlm.nih.gov/38206442/). The facility staff did not follow their procedure to verify code status prior to initiating</p>	F 578	<p>Resident # 1 was transferred to Good Samaritan Hospital and was pronounced _____ at 5:51AM in the ER by Hospital personnel. No further corrective action could be taken</p> <p>An audit was completed on _____ of current residents by the Unit Managers to ensure that residents with a _____ have Form 1896 with appropriate signatures and date in their medical record and a copy in a red binder located at each nurses station. irregularities were immediately corrected.</p> <p>Code status for new admissions and re-admissions will be reviewed daily Monday to Friday in AM clinical meeting</p>	

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F 578	<p>Continued From page 3</p> <p>These actions resulted in the identification of Immediate Jeopardy. The facility administrator was informed of the Immediate Jeopardy on at 9:45 AM. The Immediate Jeopardy was removed after verification of the facility's removal plan on _____, with an effective date of _____. The scope and severity was reduced to "D", no actual harm with potential for more than minimum harm.</p> <p>At the time of the investigation, there were 63 residents who were identified as _____ status.</p> <p>The findings included:</p> <p>A review of the facility's policy titled Advanced Directives and Code Status, dated _____ and _____, revealed the code status order will be documented in the electronic record and will serve as the primary source of validation of code status by a licensed nurse should a resident be found unresponsive. If the electronic record has an order for _____, then _____ will not be initiated. If the electronic record is down, the code status must be verified by a licensed nurse using the backup code status notebook. The State of Florida _____ form will be used to communicate a resident's _____ code status wishes to 911/Emergency Medical Services (_____) should the resident be found unresponsive.</p> <p>Record review revealed Resident #1 was admitted to the facility on _____, with diagnoses that included _____ of the _____, (_____), Type 2 _____, _____, _____, and _____ . A comprehensive assessment dated _____</p>	F 578	<p>by the Inter Disciplinary Team and on weekends by the Nursing Supervisor to ensure medical records reflect accurate code status and a copy of Form 1896 that is appropriately signed and dated _____ is uploaded in the EHR and a copy is in the binder at the nurses station if there is a _____ order present</p> <p>An audit of crash carts located on each nurses station was completed on _____ by the Director of Clinical Services to ensure equipment was readily available in an emergency.</p> <p>An audit was completed on _____ by the HR Manager to ensure that current Licensed Nurses have a valid license in place, one nurse had no current _____ on file but has since been completed on _____</p> <p>Newly hired Licensed Nurses _____ cards will be verified during the Orientation process.</p> <p>Current Team members were reeducated started on _____ by the Director of Education and/or Designee on Code status, _____ policy, _____, and neglect and validation of code status in PCC.</p> <p>100% compliance was achieved on _____ . License Nurses Education to include _____ policy and procedure written post quiz on code status and code _____</p>		

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F 578	<p>Continued From page 4</p> <p>documented the resident was and required substantial/ with activities of daily living.</p> <p>Resident #1 was care planned for a on . An intervention included to verify the presence of physician order for a</p> <p>The resident had an order for date .</p> <p>Resident #1's form/document was signed on by the resident. The document was signed by the physician, but not dated.</p> <p>A review of Resident #1's progress notes, written by Staff Nurse A, a Licensed Practical Nurse (LPN), dated at 5:30 AM, revealed Resident #1 became unresponsive while care was being provided by Staff B, a Certified Nursing Assistant (CNA) and Staff C, a Certified Nursing Assistant (CNA). Staff Nurse A went to the room and the resident was difficult to arouse. Staff Nurse A, checked the computer for the code status, which was a . Staff A then proceeded to check the status binder for a signed yellow document, which was not in the binder. Staff Nurse A returned to the room, tried to arouse the resident again without success, and called 911. There was no documentation in the progress note on whether or not the nurse assessed the resident for a or or that she had initiated . The progress note stated the resident was transferred to the hospital for further evaluation and treatment.</p> <p>During an interview with the Director of Nursing (DON) on at 11:30 AM. The DON acknowledged Resident #1 had a Do Not</p>	F 578	<p>procedures for all licensed nurses, checking code status in PCC by a Licensed nurse if a resident was discovered to be pulseless prior to initiating . Attestations were signed for acknowledgement and understanding of policy.</p> <p>New hires will be educated on the policy during the orientation process by the Director of Education/designee, with written post quiz to ensure competency.</p> <p>Enhanced Code blue drills were conducted started on on the shift, every shift x 7 days, then every other day on different shift x 7 days, then weekly x 7 then one on each shift monthly to include weekends by the Director of Education and/or designee. Re-education post drills as needed.</p> <p>Code Blue Drills will continue monthly by the Director of Education/designee one on each shift to include weekends and holidays. Results will be presented at monthly QAPI meetings to ensure ongoing compliance.</p> <p>The Social Service Director/designee will continue weekly audits of orders to ensure that orders are accurate, and that Form 1896 is appropriately signed and dated and is in place in the EHR, and a copy is in the red binder at the nurses station in the event of a PCC or power</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF WEST PALM BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL. 33401	
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F 578	<p>Continued From page 5</p> <p>Order () and a signed document.</p> <p>During an interview with the Unit Manager (UM) on _____ at 1:20 PM. The UM stated she received a call on _____ at approximately 5:55 AM from Staff A, who stated Resident #1 was being dressed for _____ and stopped talking. The resident was not responding. The UM asked for the code status of the resident, and was told the resident was a _____ and had been sent out. The UM stated she called the nurse _____ and asked if she did _____, and nurse stated "yes". Then the UM called the Director of Nursing (DON) to inform her of the incident. The UM stated when she came in the facility, Resident #1 did not have a _____ form/document in the "Red book/ _____ status binder". The UM stated, she printed out the form and placed it in the binder. The UM stated, residents should have a _____ form in the binder for when residents transfer out, or in the case of a power outage.</p> <p>A telephone interview was conducted with the Risk Manager (RM) via telephone on _____ at 2:30 PM. The RM stated, he was notified via telephone that Resident #1 was sent out via 911 on _____. The RM stated, he started a chart review and spoke to staff about what occurred. The RM reviewed the surveillance cameras, and interviewed Staff A, Staff B, and Staff C, who all provided written statements. The RM stated, the root cause analysis was human error. The RM stated, Staff A knew Resident #1 had an order for a _____ in the electronic records, but second guessed herself and looked in the _____ status binder. The RM further stated that Staff A stated she did _____ on the resident.</p>	F 578	<p>outage.</p> <p>New hires will be educated on the centers policy during the Orientation process by the Director or Education or designee with written post quiz and attestations to ensure competency.</p> <p>Results of audits will be presented at the Monthly QAPI meeting to ensure ongoing compliance.</p>	

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F 578	<p>Continued From page 6</p> <p>During an interview on _____ at 4:00 PM with Staff Nurse A, LPN, Staff Nurse A explained that 10 minutes prior to the incident, Resident #1 was getting ready for _____ and being helped by two CNAs, Staff B and Staff C. When she got notified of the resident being unresponsive, she was shocked, ran to the room, shook him and called his name, and there was no response. Staff A stated she went _____ to the nursing station, checked the _____ Status binder and did not find the _____ document. Staff A stated she called 911 and the operator said to start _____. Staff A stated she got the crash cart and went to the resident's room, a few seconds later arrived. Staff A stated, "there was no time for me to perform _____." _____ was started by _____. Staff A stated that in the 8 years that she had been working in this facility, she was always told that the confirmation of a _____ status relied on the yellow _____ document in the binder on each unit. If no _____ document was found in the binder, the resident should be treated like a full code. But they changed management so many times. Staff A stated she did not tell the 911 operator or _____ that the resident had a _____ order because they did not ask.</p> <p>There was conflicting information from Staff Nurse A's interview with the surveyors. Staff A stated to the surveyors that she did not initiate _____ prior to arriving. However, a review of the _____ report, dated _____ 05:24 AM, stated upon their arrival Rescue found the patient lying supine in a hospital bed with _____ in progress. On _____, the DON provided a copy of the Advance Directive Acknowledgment form signed by Staff Nurse A, dated _____, which</p>	F 578			

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F 578	<p>Continued From page 7</p> <p>demonstrated Staff Nurse A had read and understood the facility's Advance Directive policy, which stated that the primary source to verify code status is the order in the electronic health record in PCC (Point Click Care).</p> <p>During an interview with the Social Service Director (SSD) on _____ at 5:00 PM. The SSD stated her department is responsible for placing documents in the chart and binder. Before the document is placed in the _____ status binder, it has to be signed and dated by resident/representative and physician. The document is placed in the binder and scanned into the electronic medical record (EMR) within the same day. The SSD stated she probably took the resident's _____ document from the binder, scanned it into EMR, and did not replace it into the binder. The SSD stated it is an expectation that every resident that has a _____ order has a _____ document in the _____ status binder.</p> <p>On _____ the surveyors reviewed the _____ surveillance footage which showed the paramedics wheeling Resident #1 down the hallway of the facility with the _____ machine operating and ambu bag for _____ (the full form of AMBU is _____ Manual Breathing Unit. This device is used to provide positive pressure _____ to patients who are not breathing or not breathing adequately).</p> <p>A review of the hospital emergency department admission record, dated _____ at 5:47 AM, revealed Resident #1 was admitted while receiving _____. The hospital emergency</p>	F 578		

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F 578	<p>Continued From page 8</p> <p>department notes documented was called for patient unresponsiveness, the call was placed approximately 10 minutes prior to their arrival. There was no on their arrival. At the time of the patient arrival in the Emergency Department, there had been no for at least 30 minutes.</p> <p>IJ Removal:</p> <p>On the facility provided an acceptable plan to remove the Immediate Jeopardy. The plan included the following immediate actions which were verified as implemented before the survey exit to prevent this event from reoccurring:</p> <ol style="list-style-type: none"> Resident pronounced at 5:51 AM by hospital personnel. MD was notified that the resident was transported to the hospital. Notification to unit manager. Notification of event to DCS (Director of Clinical Services). Notification to ED (Executive Director) - Education on code status, policy, and neglect policy initiated for current license staff. With post quiz and attestation. - New hired licensed nurses will be educated on the advanced directive policy with post quiz and attestation. Ongoing. Resident's chart review completed. Audit of medical records of current residents to validate orders. Federal immediate report submitted with the notification to DCF and law enforcement. Code books reviewed for accuracy. Books located at each nursing station. 	F 578		

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F 578	Continued From page 9 12. The nurse involved in the incident was removed from the schedule pending investigation. 13. Code blue drills to be performed as follows: every shift times 7 days, then every other day on different shift times 7 days, then weekly times 7 days, then monthly to include weekends and holidays starting on _____ until all nurses have attended a code blue drill with no deficiencies, alternating different scenarios of code status to increase staff understanding. 14. Medical director notified of events and interventions. 15. Crash carts audited. 16. - cards audited for validation. 17. Ad hoc meeting with Interdisciplinary Team (IDT) and medical director. 18. - Quiz presented to licensed nurses to validate knowledge on code status and procedures competency as needed. 19. Licensed nurse hires to be educated on current advanced directive policy attestation and competency and post quiz. Ongoing. 20. New admissions/readmissions records to be reviewed daily Monday through Friday and AM clinical meeting on weekends by the nursing supervisor for accurate status. Ongoing. 21. Reeducate SSD, UM, DCS, DQA on policy and obtaining form DH1896 (document) with physician and resident representative signature as soon as an order is received for _____ 22. - ongoing SSD/designee will do audit daily Monday through Friday during clinical meeting of binders kept at the nurses' station to ensure that form 1896 is in place for those	F 578			

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F 578	<p>Continued From page 10</p> <p>residents with an order for</p> <p>23. - ongoing Results and outcome of audits of binders for Form 1896 to be presented monthly.</p> <p>24. - audit results and outcome of drills to be presented weekly times 3 at ad hoc meeting. Then monthly times three months or until compliance to determine the effectiveness of the plan. Plan to be revised as necessary.</p> <p>25. Federal five day report submitted.</p> <p>26. Report to the board of nursing.</p> <p>27. - Physician to be re educated on signing and dating Form 1896.</p> <p>IJ Removal date</p> <p>Review of the in-service attendance sheets validated the participation of licensed staff education on the above topics. 100% of the nurses were in-serviced.</p> <p>Review of the code blue audits revealed no concerns.</p> <p>On and , interviews were conducted with licensed staff that represented all three shifts. All staff interviewed confirmed they were made aware of the incident that involve a resident with a status that received . They verbalized understanding the education provided and verified participation in at least one mock Code Blue drill. SSD acknowledged education on ensuring resident's document was signed and dated by resident/representative, and placed in the status binder on each unit, and continued audits.</p> <p>A telephone interview was conducted with the Medical Director on at 11:00 AM. He</p>	F 578			

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