Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	74830	A. BUILDING: _____ B. WING _____	C 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER TOWERS	70 WEST LUCERNE CIRCLE ORLANDO, FL 32801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS Complaint Survey #2025002364 was conducted from through . Westminster Towers had deficiencies found at the time of the visit. Complaint #2025002364 was substantiated, and noncompliance was identified for N201 at Class I starting on . A Class I deficiency is one which the agency determines presents an imminent danger to the residents or guests of the facility or a substantial probability that or serious physical harm would result therefrom. The condition or practice constituting a Class I violation must be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. On at approximately 7:00 PM, Registered Nurse (RN) A observed resident #1 in bed and unresponsive. RN A failed to verify resident #1's code status and did not provide life saving measures including , { } per resident #1's wishes. RN A notified RN C of resident #1's and they provided postmortem care. RN A then notified RN Supervisor B of resident #1's and was instructed to contact hospice and the family. The facility failed to honor resident #1's wish to be and physician order for Full Code. The facility's failure to honor a Full Code resulted in resident #1 not being provided resuscitative measures contributing to her . The facility's failure to verify the code status of a resident on hospice care put all residents on hospice services at risk of not receiving if desired. The facility's Administrator was notified of the	N 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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N 000	Continued From page 1 Class I deficiency on at 12:25 PM. The census at the start of the survey was 90.	N 000		
N 201 SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) 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. This Statute or Rule is not met as evidenced by: Based on interview, and record review, licensed nurses failed to follow the facility's policy and procedure for , ( ) related to verification of code status in an emergency for 1 of 13 residents reviewed for advance directives, (#1). On at approximately 7:00 PM, resident #1 was observed unresponsive in her bed. Registered Nurse (RN) A took her vitals and notified RN C resident #1 had , . RN A failed to verify resident #1's code status and failed to provide per her wishes. Emergency Medical Services was never called. The facility failed to honor the resident's wish to be and the physician order for Full Code status. The facility's failure to ensure staff followed procedures related to honoring an advance directive to provide lifesaving measures including	N 201	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both federal and State laws. 1. Resident #1 expired on . Nurse A and Nurse B were suspended immediately. 2. Residents who , in house in the past 3 months were reviewed to ensure all advanced directives were followed. This was completed by and no discrepancies were noted. All Code statuses were followed as ordered. Social services validated all current	

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N 201	Continued From page 2 for a resident on hospice care contributed to resident #1's . This action placed all residents who received hospice care at risk of not having their wishes honored. This failure resulted in Immediate Jeopardy starting on . The Immediate Jeopardy was removed on . The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings: Resident #1 was an , female admitted to the facility on with diagnoses including unspecified sequelae of ( ), adult , moderate protein-calorie , major , and atherosclerotic (hardening of the). Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date of revealed resident #1 had a score of which indicated she had severe , . The document revealed she had a prognosis that might result in a life expectancy of less than six months and she received hospice care. Review of the electronic medical record (EMR) revealed a social services progress note dated which indicated the Social Services Director (SSD) spoke with resident #1 and her husband regarding her code status. The resident and her husband rescinded her previous ( ) order to become a full code. Resident #1's husband stated to the SSD that was what his wife wanted.	N 201	residents code status and validated the status is correct according to their individual wishes on . Nurse A is no longer employed at the facility and the results of the investigation were reported to the board of nursing. Education was provided to Nurse B prior returning to work. 3.Facility completed code blue drills each shift 72 hours post incident and re-educated staff on our code blue policies. Completed by Staff received an electronic communication with immediate education on resident rights, advanced directives, and validating residents code status in their chart prior to calling a code blue on . The nursing supervisors were re-educated by the ADON and/or designee by regarding verifying code status on any resident found without vital signs or unresponsive prior to having contact with residents. Licensed nurses have been in serviced by the ADON and/or designee by that residents receiving hospice service does not equate to the resident being a and staff must check all residents code status when they are found unresponsive. This was completed prior to having contact with residents. A new process was put into place where the Facility will add residents full code status order to the MAR to be signed off	

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N 201	Continued From page 3 Resident #1 had a care plan for advanced directives initiated on . The focus indicated the advanced directives had been reviewed and included, "FULL CODE." The goal was the resident's wishes would be honored through the next review date. Interventions included for staff to make the resident's wishes known through the care continuum. Resident #1's EMR contained a physician order dated which read, "Full Code." The words "Full Code" were displayed under the "Advance Directive" section on the Medication Administration Record for . A care plan meeting was held on with resident #1's husband. Code status was reviewed and no changes were made to her advanced directives. A progress note dated for read, "She remains a Full Code status currently." A Health Status Note dated at 4:02 PM, indicated resident #1 had an saturation rate of 80% and an order was obtained for 2 liters of via . Hospice was contacted and orders for , and were received. No other notes were recorded until at 9:11 PM which indicated resident #1 was pronounced at approximately 8:15 PM. The note indicated family and hospice were present at that time after being contacted by the facility. In a phone interview on at 1:22 PM, RN A verified she was assigned to resident #1 on the 3:00-11:00 PM shift on . She recalled the nurse from the previous shift reported resident #1 was not doing well and hospice had been notified. RN A stated resident #1's husband approached her earlier on the 3:00-11:00 PM shift and	N 201	every shift by the nurse if the patient is on hospice and is a full code to increase visibility to nursing staff on . Written Code blue competency tests were administered to the licensed staff and CNAs and validated by the DON/Designee. Regularly scheduled staff completed by and PRN staff will complete testing prior to having contact with residents. Any new staff members will receive code blue education and competency testing during their orientation days before working the floor alone ongoing. Facility staff were re-educated by the ADON and/or designee of the advance directive processes; , neglect and ; resident's rights regarding treatment and advance directives; communication of code status; and physician notification of changes. Regularly scheduled staff completed by and PRN staff will complete education prior to having contact with residents. 4. Facility completed ad hoc QAPI on and continued with ad hoc QAPI for the following three weeks on , and . Code blue drills varying day/shift will continue weekly for one month, followed by three drills a month varying day/shift monthly thereafter to be completed by DON/designee.	

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N 201	Continued From page 4 requested she contact hospice again for someone to come and evaluate her for crisis care. She explained the resident's husband expressed he wanted her to be comfortable and not suffer. RN A recalled she entered resident #1's room later at approximately 7:00 PM and observed the resident was unresponsive and did not appear to be breathing. She stated she checked resident #1's vital signs and did not find a , or , . RN A explained she asked RN C to assist and they provided postmortem care. RN A verified she did not initiate . She explained resident #1 received hospice services and she had always known resident #1 to be a code status. RN A acknowledged she was not aware resident #1 had Full Code status. She stated the facility procedure was to look in the resident's chart to verify the resident's code status. RN A acknowledged she would have realized the resident was a Full Code and not a if she had looked in the chart. In a phone interview on at 3:24 PM, RN C verified she was working on the 3:00-11:00 PM shift on but was not assigned to resident #1. RN C recalled she was in a room with another resident when RN A approached her and informed her resident #1 had expired. RN C stated she went to resident #1's room afterwards and asked if everything had been done and was told it had. She reported she assisted RN A in providing postmortem care. RN C explained she did not hear a Code Blue announcement and thought RN A had verified resident #1's code status prior to alerting her to resident #1's . . RN C stated procedure was to call a Code Blue if a resident was found unresponsive and staff would come with the crash cart and the resident's chart to verify code status prior to initiating . .	N 201	Random weekly checks will be completed by DON and/or designee for three months to ensure the nurses & CNAs are competent with checking the residents code status when a resident is found unresponsive, regardless of status, ie Hospice, STR, etc. ADON and/or designee will complete Weekly audits of current hospice residents to ensure there is a separate order being signed off stating the resident full code status if appropriate. Audits will be completed weekly for one month, followed by monthly for two months. DON and/or Designee will audit any new hires to ensure a code blue competency test has been satisfactorily completed monthly x3 months. Incident was reviewed during QAPI meeting on and committee agrees with this corrective action. Results of the previously mentioned audits including checking the code status, code blue drills, auditing of hospice resident orders, physician notification of change of condition for full code hospice residents and new hire competencies will be submitted to the Administrator and brought to QAPI for review and evaluation monthly. Audits will continue for a minimum of 3 months or until significant compliance has been met as deemed by the QAPI committee.	

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N 201	Continued From page 5 In a phone interview on at 12:54 PM, RN Supervisor B confirmed she was working the 3:00-11:00 PM shift on . She recalled being on a different floor orienting a new resident and their answering questions when RN A called to let her know resident #1 had expired. RN Supervisor B stated she went to the other floor and confirmed resident #1 had no vital signs. She proceeded to call the hospice and inform them of the resident's . RN Supervisor B explained she assumed resident #1 was a because she was under hospice care. She stated she was not aware a resident could be Full Code under hospice care. RN Supervisor B explained that RN A did not inform her resident #1 was a Full Code. She acknowledged she did not verify the resident's code status as she thought RN A had already done so. RN Supervisor B expressed she was not aware there was an error until the Director of Nursing contacted her a few days later on . On at 2:14 PM, resident #1's husband confirmed she desired to have resuscitative measures and be a Full Code. He explained his wife had been very active in the community prior to her in but had not been the same since. He recalled signing up for hospice care a couple of months ago but was not sure what could be done for her as she refused a lot of care. He reported during the last week of her life, he would ask how she was doing, and she would reply, "I am still here," if she said anything at all. Resident #1's husband recalled she was not very responsive during his visit earlier in the day on . He left to go to dinner and was later notified he needed to return to the health center because she had , . Resident #1's husband again confirmed she was a Full Code and explained he did not think would benefit	N 201		

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N 201	Continued From page 6 her, but it was her wish to have it performed. He expressed he was not going to argue with her. On at 2:41 PM, the Administrator stated he and the Director of Nursing (DON) were notified of resident #1's on but were not notified she had full code orders. He recalled the 3rd Floor Assistant Director of Nursing notified him and the DON of discrepancies in the documentation regarding resident #1's . The documentation was reviewed and did not appear to support the events of that evening. The Administrator reported they could not reach RN A until 1:52 PM on to get details of what had occurred. He stated from the interviews with RN A, RN C and RN Supervisor B, they determined a Code Blue was not called and resident #1 was not provided . The Administrator acknowledged RN A failed to verify resident #1's code status per facility policy and therefore did not initiate . He reported resident #1 was later pronounced by the hospice nurse and her body was removed by the funeral home. The Facility's policy and procedure for dated read, "If a resident experiences a , facility staff will provide basic life support, including , prior to the arrival of emergency medical services, and in accordance with the resident's advance directives." Class I	N 201		

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F 000	INITIAL COMMENTS Complaint Survey #2025002364 was conducted from through . Westminster Towers was not in compliance with 42 CFR 483 and 488, requirements for Long Term Care Facilities. Complaint #2025002364 was substantiated, and noncompliance was identified for F678 at scope and severity of J, Immediate Jeopardy, starting on . 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. On at approximately 7:00 PM, Registered Nurse (RN) A observed resident #1 in bed and unresponsive. RN A did not verify resident #1's code status and failed to provide life saving measures including , ( ) per resident #1's wishes. RN A notified RN C that resident #1 had expired and they provided postmortem care. RN A then notified RN Supervisor B resident #1 had expired and was instructed to contact hospice and the family. The facility failed to honor resident #1's wishes to be and the physician order for Full Code. The facility's failure to honor a Full Code resulted in resident #1 not being provided resuscitative measures contributing to her . The facility's Administrator was notified of the Immediate Jeopardy (IJ) on at 12:25 PM and provided with the IJ templates for F678. The Immediate Jeopardy was determined to be	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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 removed on after verification of the immediate actions implemented by the facility. Substandard Quality of Care was identified at F678. An extended survey was conducted on . The census at the start of the survey was 90.	F 000		
F 678 SS=J	- , ( ) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including , to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, licensed nurses failed to follow the facility's policy and procedure for , , ( ) related to verification of code status in an emergency for 1 of 13 residents reviewed for advance directives, (#1). On at approximately 7:00 PM, resident #1 was observed unresponsive in her bed. Registered Nurse (RN) A took her vitals and notified RN C resident #1 had , , RN A failed to verify resident #1's code status and failed to provide per her wishes. Emergency Medical Services was never called. The facility failed to honor the resident's wish to be and the physician order for Full Code status. The facility's failure to ensure staff followed	F 678	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both federal and State laws. 1. Resident #1 expired on . Nurse A and Nurse B were suspended immediately. 2. Residents who , in house in the past 3 months were reviewed to ensure all advanced directives were followed. This was completed by and no discrepancies were noted. All Code statuses were followed as ordered.	

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F 678	Continued From page 2	F 678		

procedures related to honoring an advance directive to provide lifesaving measures including for a resident on hospice care contributed to resident #1's . This action placed all residents who received hospice care at risk of not having their wishes honored. This failure resulted in Immediate Jeopardy starting on . The Immediate Jeopardy was removed on . The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.

Findings:

Resident #1 was an female admitted to the facility on with diagnoses including unspecified sequelae of ( ), adult , moderate protein-calorie , major , and atherosclerotic (hardening of the).

Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date of revealed resident #1 had a score of which indicated she had severe . The document revealed she had a prognosis that might result in a life expectancy of less than six months and she received hospice care.

Review of the electronic medical record (EMR) revealed a social services progress note dated which indicated the Social Services Director (SSD) spoke with resident #1 and her husband regarding her code status. The resident and her husband rescinded her previous ( ) order to become a full code.

Social services validated all current residents code status and validated the status is correct according to their individual wishes on . Nurse A is no longer employed at the facility and the results of the investigation were reported to the board of nursing. Education was provided to Nurse B prior returning to work.

3.Facility completed code blue drills each shift 72 hours post incident and re-educated staff on our code blue policies. Completed by

Staff received an electronic communication with immediate education on resident rights, advanced directives, and validating residents code status in their chart prior to calling a code blue on .

The nursing supervisors were re-educated by the ADON and/or designee by regarding verifying code status on any resident found without vital signs or unresponsive prior to having contact with residents.

Licensed nurses have been in serviced by the ADON and/or designee by that residents receiving hospice service does not equate to the resident being a and staff must check all residents code status when they are found unresponsive. This was completed prior to having contact with residents.

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F 678	Continued From page 3 Resident #1's husband stated to the SSD that was what his wife wanted. Resident #1 had a care plan for advanced directives initiated on . The focus indicated the advanced directives had been reviewed and included, "FULL CODE." The goal was the resident's wishes would be honored through the next review date. Interventions included for staff to make the resident's wishes known through the care continuum. Resident #1's EMR contained a physician order dated which read, "Full Code." The words "Full Code" were displayed under the "Advance Directive" section on the Medication Administration Record for , . A care plan meeting was held on with resident #1's husband. Code status was reviewed and no changes were made to her advanced directives. A progress note dated for read, "She remains a Full Code status currently." A Health Status Note dated at 4:02 PM, indicated resident #1 had an , , saturation rate of 80% and an order was obtained for 2 liters of , , via . Hospice was contacted and orders for , and were received. No other notes were recorded until at 9:11 PM which indicated resident #1 was pronounced at approximately 8:15 PM. The note indicated family and hospice were present at that time after being contacted by the facility. In a phone interview on at 1:22 PM, RN A verified she was assigned to resident #1 on the 3:00-11:00 PM shift on . She recalled the	F 678	A new process was put into place where the Facility will add residents full code status order to the MAR to be signed off every shift by the nurse if the patient is on hospice and is a full code to increase visibility to nursing staff on . Written Code blue competency tests were administered to the licensed staff and CNAs and validated by the DON/Designee. Regularly scheduled staff completed by and PRN staff will complete testing prior to having contact with residents. Any new staff members will receive code blue education and competency testing during their orientation days before working the floor alone ongoing. Facility staff were re-educated by the ADON and/or designee of the advance directive processes; , neglect and , ; resident's rights regarding treatment and advance directives; communication of code status; and physician notification of changes. Regularly scheduled staff completed by and PRN staff will complete education prior to having contact with residents. 4. Facility completed ad hoc QAPI on and continued with ad hoc QAPI for the following three weeks on , and . Code blue drills varying day/shift will	

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F 678	Continued From page 4 nurse from the previous shift reported resident #1 was not doing well and hospice had been notified. RN A stated resident #1's husband approached her earlier on the 3:00-11:00 PM shift and requested she contact hospice again for someone to come and evaluate her for crisis care. She explained the resident's husband expressed he wanted her to be comfortable and not suffer. RN A recalled she entered resident #1's room later at approximately 7:00 PM and observed the resident was unresponsive and did not appear to be breathing. She stated she checked resident #1's vital signs and did not find a , or , . RN A explained she asked RN C to assist and they provided postmortem care. RN A verified she did not initiate . She explained resident #1 received hospice services and she had always known resident #1 to be a code status. RN A acknowledged she was not aware resident #1 had Full Code status. She stated the facility procedure was to look in the resident's chart to verify the resident's code status. RN A acknowledged she would have realized the resident was a Full Code and not a if she had looked in the chart. In a phone interview on at 3:24 PM, RN C verified she was working on the 3:00-11:00 PM shift on but was not assigned to resident #1. RN C recalled she was in a room with another resident when RN A approached her and informed her resident #1 had expired. RN C stated she went to resident #1's room afterwards and asked if everything had been done and was told it had. She reported she assisted RN A in providing postmortem care. RN C explained she did not hear a Code Blue announcement and thought RN A had verified resident #1's code status prior to alerting her to resident #1's .	F 678	continue weekly for one month, followed by three drills a month varying day/shift monthly thereafter to be completed by DON/designee. Random weekly checks will be completed by DON and/or designee for three months to ensure the nurses & CNAs are competent with checking the residents code status when a resident is found unresponsive, regardless of status, ie Hospice, STR, etc. ADON and/or designee will complete Weekly audits of current hospice residents to ensure there is a separate order being signed off stating the resident full code status if appropriate. Audits will be completed weekly for one month, followed by monthly for two months. DON and/or Designee will audit any new hires to ensure a code blue competency test has been satisfactorily completed monthly x3 months. Incident was reviewed during QAPI meeting on and committee agrees with this corrective action. Results of the previously mentioned audits including checking the code status, code blue drills, auditing of hospice resident orders, physician notification of change of condition for full code hospice residents and new hire competencies will be submitted to the Administrator and brought to QAPI for review and evaluation monthly. Audits will continue for a	

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	105757	A. BUILDING _____ B. WING _____	C 03/04/2025

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F 678	Continued From page 5 RN C stated procedure was to call a Code Blue if a resident was found unresponsive and staff would come with the crash cart and the resident's chart to verify code status prior to initiating . In a phone interview on at 12:54 PM, RN Supervisor B confirmed she was working the 3:00-11:00 PM shift on . She recalled being on a different floor orienting a new resident and their answering questions when RN A called to let her know resident #1 had expired. RN Supervisor B stated she went to the other floor and confirmed resident #1 had no vital signs. She proceeded to call the hospice and inform them of the resident's . RN Supervisor B explained she assumed resident #1 was a because she was under hospice care. She stated she was not aware a resident could be Full Code under hospice care. RN Supervisor B explained that RN A did not inform her resident #1 was a Full Code. She acknowledged she did not verify the resident's code status as she thought RN A had already done so. RN Supervisor B expressed she was not aware there was an error until the Director of Nursing contacted her a few days later on . On at 2:14 PM, resident #1's husband confirmed she desired to have resuscitative measures and be a Full Code. He explained his wife had been very active in the community prior to her in but had not been the same since. He recalled signing up for hospice care a couple of months ago but was not sure what could be done for her as she refused a lot of care. He reported during the last week of her life, he would ask how she was doing, and she would reply, "I am still here," if she said anything at all. Resident #1's husband recalled she was not very	F 678	minimum of 3 months or until significant compliance has been met as deemed by the QAPI committee.	

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responsive during his visit earlier in the day on . He left to go to dinner and was later notified he needed to return to the health center because she had , . Resident #1's husband again confirmed she was a Full Code and explained he did not think would benefit her, but it was her wish to have it performed. He expressed he was not going to argue with her.

On at 2:41 PM, the Administrator stated he and the Director of Nursing (DON) were notified of resident #1's on but were not notified she had full code orders. He recalled the 3rd Floor Assistant Director of Nursing notified him and the DON of discrepancies in the documentation regarding resident #1's . The documentation was reviewed and did not appear to support the events of that evening. The Administrator reported they could not reach RN A until 1:52 PM on to get details of what had occurred. He stated from the interviews with RN A, RN C and RN Supervisor B, they determined a Code Blue was not called and resident #1 was not provided . The Administrator acknowledged RN A failed to verify resident #1's code status per facility policy and therefore did not initiate . He reported resident #1 was later pronounced by the hospice nurse and her body was removed by the funeral home.

The Facility's policy and procedure for dated , read, "If a resident experiences a , facility staff will provide basic life support, including , prior to the arrival of emergency medical services, and in accordance with the resident's advance directives."

Review of the immediate corrective measures

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implemented by the facility revealed the following, which were verified by the survey team:

*On Administrator and DON were made aware of discrepancies in resident #1's chart regarding her passing, and initiated an investigation.

*On the facility completed an in-house audit for code status of all residents. No additional issues were identified.

*On through current licensed nurses were educated on the facility's policy and on the procedure for verifying code status prior to initiating or withholding lifesaving procedures including . Code Blue drills were conducted to validate comprehension.

*On resident #1's husband was notified regarding discrepancies found and investigation.

*On law enforcement and elderly affairs were notified out of abundance of caution. An immediate report was filed with the state agency.

*On a record review of resident #1 was completed by the DON.

*On Social Service Director completed an audit of all current residents' code status. No additional residents were identified with concerns.

* On the RN Supervisor B and RN A received personal training from the DON on checking residents' code status and starting Code Blue procedures. Both nurses were suspended pending investigation.

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* On Nursing Supervisors received individual education on checking code status when residents were unresponsive and initiating Code Blue procedures from the DON.

* On a text was sent to all nursing staff containing education regarding if a resident was found unresponsive, it was the responsibility of the nurse to verify code status in the chart and initiate if Full Code

*64 of 81 total licensed nurses received education; 79% of nurses:
" On 48 out of 81 nurses completed the education, 24% of nurses
" On an additional 10 of 81 nurses completed their education, 71% of nurses
" On an additional 6 of 81 nurses completed their education, 79% of nurses
" Remaining licensed nurses would receive education prior to working next shift

*New hire nurses at the facility would receive the above education during orientation and prior to working an assignment.

*On through mock Code Blue drills were conducted every shift for 72 hours to validate education received was retained.
" Starting weekly code blue drills to be conducted on varying shifts and days to include all shifts for three months to include all shifts.
" Random weekly audits to be completed three times a week for three months to ensure staff follow facility procedure for verifying residents' code status prior to initiating or withholding .

*New hire nurses at the facility to participate in a mock code drill during orientation and prior to

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F 678	Continued From page 9 working an assignment. *Ad Hoc Quality Assurance and Performance Improvement (QAPI) held on to review the recommendations made from the investigation. Those in attendance included the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Admissions Director, Director, Unit Managers, Director of Dietary, Activities Director and MDS nurses. The QAPI committee reviewed education in progress and code blue drills. Interviews conducted on with 6 licensed nurses and 11 Certified Nursing Assistants across all shifts indicated they were knowledgeable of advanced directives and facility procedures to verify the resident's code status prior to providing . The surveyor validated the education with attendance sheets for code blue drills and in-services. Review of QAPI audits revealed daily code blue drills were conducted per performance improvement plan. The resident sample was expanded to include five additional residents currently receiving hospice services and three additional residents who expired in the facility in the last 60 days. Interviews and record reviews revealed no concerns for residents #2 through #13 related to provision of related to wishes expressed through advanced directives. Based on the facility's corrective actions, the survey team determined the Immediate Jeopardy was removed on .	F 678		