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
	41614	A. BUILDING: _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENTS PARK OF JACKSONVILLE	8700 A C SKINNER PARKWAY JACKSONVILLE, FL 32256

(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 A complaint investigation (Complaint #2021011095), in conjunction with a Focused Control visit, was conducted at Regents Park of Jacksonville on . . . . . , and continued from through . The facility had a deficiency at the time of the survey. A Class I deficiency was identified at N201. The Class I deficiency was a result of the facility's failure to ensure Agency clinical staff understood how to respond to an unresponsive resident and provide basic life support, including . . . . . (. .), as per the resident's Advance Directives and the facility's policies and procedures. Two Agency licensed practical nurses (LPNs) failed to verify Resident #1's code status after finding the resident unresponsive, and before initiating . The emergency medical response (. .) team was never notified, was stopped, and Resident #1 . . . in the facility. The facility Administrator was notified of the Class I deficiency at 4:45 p.m. on . The Class I deficiency began on at 3:16 a.m. On . . . . , the facility's census was 91. The following is a description of the deficient practice: .	N 000		

AHCA Form 3020-0001

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

Electronically Signed /21

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N 201	Continued From page 1	N 201		
N 201 SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care 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 interviews and record reviews, the facility failed to provide adequate and appropriate health care services consistent with the resident care plan and recognized practice standards within the community, by failing to ensure Agency clinical staff appropriately provided basic life support, including . . . . . ( ) to a resident (#1) requiring such emergency care, out of three residents reviewed. The facility failed to ensure Agency clinical staff 1) Verified the resident's code status prior to initiating , 2) Called emergency medical services (. .), and 3) Followed the facility's policy and procedure for : Code Status Orders and Response. On . . . . at 3:16 AM, Certified Nursing Assistant (CNA) B found Resident #1 unresponsive in bed. The resident was not breathing but was warm with coming from his . . . . . CNA B immediately summoned Agency Licensed Practical Nurse (LPN) C, who summoned Agency LPN A (the resident's assigned nurse) to the resident's room. was initiated by these two nurses without first checking the resident's code status. At 3:30 a.m.,	N 201	A. As resident is no longer residing in facility a record review of Resident #1 was performed on . . . . . by ADON. A complete and thorough Investigation was initiated and completed, and facility reported investigative findings as required. Current residents were validated on by DON & SSD to ensure advanced directives were honored. No Concerns noted. B. An initial audit was completed on of current resident code statuses then again on . . . . . by DON/Designee to ensure accuracy and advance directives were honored. No concerns identified. C. Licensed nursing staff were re-educated by the DON/designee on Advanced Directive P&P, Commitment to honoring advanced directive attestation, Code Status Orders and Response, Nurse Supervision, and code blue drills were conducted for competency. The education was completed by nursing administration by . . . . . Newly hired licensed nurses will be educated on the same. Code Blue	

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N 201	Continued From page 2 Agency LPN A left the room to check the resident's code status while Agency LPN C continued . . Resident #1 was a full code status. Registered Nurse (RN) D was summoned and was met by Agency LPN A at the nurses' station at 3:36 a.m. Without assessing Resident #1, RN D instructed Agency LPN A to check Resident #1's chart, start , and call the physician and family. She further stated if Agency LPNs A and C could not obtain a , , the resident was . . . . and there was no need to call . . RN D did not assist with or call herself. . . . was never called. At 3:37 a.m., Agency LPN A notified the on-call Advanced Practice Registered Nurse (APRN) that had been stopped and Resident #1 expired. An Class I deficiency was identified at 12:24 p.m. on . . . . . On . . . . . at 3:16 a.m., the Class I deficient practice began. On at 4:45 p.m., the Administrator was notified of the Class I determination. On . . . . . , the facility's census was 91. Any residents whose Advance Directives indicated a Full Code Status were at risk. There were 61 residents who had a Full Code status at that time. The findings include: Cross reference F726 A review of Resident #1's medical record revealed an admission on and a primary	N 201	Documentation will be reviewed 5 times a week in Clinical Meeting to ensure residents advanced directive were honored. Any issues identified during the meeting will be addressed at that time. D. Weekly audits of staff understanding of education will be conducted by the DON/designee for 4 weeks, then monthly x 2. These audits will be presented to Quality Assurance Meeting x 3 months or until substantial compliance by the director of nursing for review and revision of the current audit plan.	

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N 201	Continued From page 3 diagnosis of wasting and atrophy. Secondary diagnoses included , (fast rate), atherosclerotic (build-up in blocking flow), (blocked) and (clot) of other specified veins, novel coronavirus COVID-19, and ( ). The resident's discharge was noted as , and his physician's orders included full . The Admission Minimum Data Set (MDS) assessment, dated , indicated that the resident had a ( ) score of 15 out of a possible 15 points, indicating intact cognition. Resident #1 required with bed mobility and toilet use, limited assistance with transfers, and was independent with set-up for meals. His care plan for Advance Directives indicated the resident's wish to be a Full Code should he become unresponsive. An interview was conducted with the Regional Director of Risk Management on at 11:05 a.m. regarding the resident's discharge. She confirmed that there was no documentation about his discharge, therefore information was obtained from the facility's investigation of the event. She provided the following timeline: On during routine rounding at 3:16 a.m., CNA B observed Resident #1 in his bed with is closed and coming out of his . He was not breathing and his overall color was "different". Previous rounding conducted at 1:55 a.m. revealed the resident was still warm to the touch. CNA B summoned for a nurse and Agency LPN C came to the room. While donning personal protective equipment (PPE) to get into the COVID-19 unit, she contacted Agency LPN A (primary nurse assigned	N 201		

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N 201	Continued From page 4 to Resident #1), who was on break, to come to the unit. Upon entering the resident's room at 3:17 a.m., Agency LPN A assessed Resident #1. After determining that the resident had no , she initiated . Agency LPN C then asked CNA B to get linen to clean the resident. At around 3:18 a.m., Agency LPN A (primary nurse), entered the room and assisted Agency LPN C with , . After five minutes, Agency LPN C took over , again and asked Agency LPN A to check the resident's chart and confirm the code status. As Agency LPN C continued with , , she contacted Registered Nurse (RN Supervisor) D over her personal phone via SIRI (voice-activated personal assistant that is part of Apple Inc.'s iOS, iPadOS, watchOS, macOS, and tvOS operating systems) to come to the unit, as there was an incident. RN D, who was on lunch break, was not provided with any details about which unit or room number Agency LPN C was referring to. When RN D arrived on the unit at approximately 3:25 a.m., she did not find anyone at the nurses' station and proceeded to care for her assigned resident. At 3:30 a.m., Agency LPN A went to the nurses station to verify Resident #1's code status. She noted that Resident#1 was a Full Code. She did not call or overhead page "Code Blue" per the facility's policy and procedure. She notified Agency LPN C that Resident #1 was a Full Code and to continue . At 3:36 a.m., RN D returned to the nurses' station from her assigned resident's room and found Agency LPN A there. Agency LPN A notified RN D that Resident #1 was unresponsive. RN D asked Agency LPN A to note the resident's time of and contact the family and physician. RN D stated there was no need to contact , as the resident had . In a telephone interview on at 12:40 p.m,	N 201		

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N 201	Continued From page 5 CNA B stated Resident #1 was on the COVID unit. When she went to check his vital signs, she noted that he "was not himself" and had coming from his . He was warm to the touch. She summoned for the nurse on the non-COVID unit (LPN C), as she could not locate the nurse on the COVID unit (Agency LPN A). Agency LPN C responded. While donning PPE to enter the COVID unit, Agency LPN C contacted Agency LPN A, the nurse assigned to the COVID unit. Moments after that, Agency LPN C assessed the resident and initiated . She then asked CNA B to get supplies to clean the resident's oral . CNA B left the room to get supplies. She stated she had to get the linen from a different nursing unit. CNA B added that she did "not even know" the resident was a full code, as the nurses were slow to act and did not announce "Code Blue" on the overhead paging system. She said when she returned to the COVID unit, the nurses had already stopped and she cleaned the resident. CNA B could not recall the time she returned to the unit. In a telephone interview on at 12:44 p.m., Agency LPN A stated she could not remember the incident exactly. She mentioned that she provided the facility with a statement about the incident and stated that a copy could be obtained. (Copy obtained) Agency LPN A confirmed that she did not call per the protocol. She stated RN D told her there was no need to call if the resident was . When Agency LPN A was asked whether RN D assessed Resident #1 in order to make this determination, Agency LPN A stated "no". At that time, Agency LPN A abruptly ended the interview. On at 1:30 p.m., the Regional Director of Risk Management was interviewed. She stated	N 201		

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N 201	Continued From page 6 she helped conduct the facility's investigation, and the nurses involved did not follow the facility's policy for Code Response. She added that in the event a resident was found unresponsive, the staff were expected to page Code Blue overhead with a room number, and designate one person to oversee the process, including calling . . while others performed , . She confirmed the staff did not do any of the above. RN D/RN Supervisor, did not help the nurses with the or assess the resident. She added that the facility had enough staff working that night, but they were not aware of the incident, as Agency LPNs A and C did not page Code Blue overhead or call . . They also failed to document the event. During a telephone interview with the APRN on . . . . at 2:10 p.m., she stated she was on call the night of . Facility staff paged her stating [Resident #1] had expired. She stated she called right to acknowledge she had received the page. Staff did not ask her whether they should stop . She was not familiar with the resident, and was not aware that the resident was a full code, so she told the staff she would relay the information to the attending physician. In a telephone interview on . . . . at 3:30 p.m., the Medical Director (the resident's physician) stated he was notified of the incident the following morning by the on-call APRN. The APRN told him that staff notified her the resident had expired, but she was not informed that the resident was a full code. When asked his expectations on such a scenario, he stated he was not sure why the staff did not call . . . to honor the resident's wishes. He added that [Resident #1] was his patient, and it was a ". . . to hear of his ".	N 201		

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N 201	Continued From page 7 A review of the facility's policy and procedure titled : Code status Orders and Response (Effective) revealed: Policy - The facility provides Basic Life Support (BLS) only. The physician's orders for full code or are written based on the wishes of the resident/resident representative. Advance Directives will be honored. On admission Staff will verify the presence of Advanced Directives documents and confirm resident or resident representative wishes with regard to . The resident will be considered a full code unless the resident/representative wishes to change their decision. 1. Obtain advanced directives decision making documents at the time of admission. If not available at time of admission, request the resident representative to bring a copies to the facility as soon as possible. 2. Discuss Code preference with the resident/resident representative. 3. Document resident/resident representative preferences in the medical record if the resident's wishes are different than the admission orders or if the orders do not address the code status, and the resident does not want to receive , staff will document resident's wishes in the record and contact the physician to obtain the order. 4. Notify physician if the resident/resident representative preferences change, and obtain order. In the event that the physician is not available, the Medical Director may be contacted for the order. 5. While awaiting the physician's order to withhold , the facility should document	N 201		

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N 201	Continued From page 8 discussion with the resident/representative's verbalized wish to refuse . If the resident or resident representative verbalizes the wish not to receive , two staff members will witness and document this request. The conversation of the request will be printed and placed as the first document of the medical record. a. While the physician's order is pending, staff will honor the documented verbal wishes of the resident or the resident's representative regarding Quarterly/ PRN 1. Review and discuss code status with the resident/resident representative and confirm code status is unchanged. Document wishes are unchanged in the medical records. 2. If resident or resident representative wishes to change status, document in the record and notify physician to obtain the order. 6. Social Services and/or nursing should discuss Advance Directive decision with the resident/resident representative to ascertain that the resident/resident representative understands the decision. 7. Notify attending MD of the resident/resident representative request for or Full Code status. Residents' wishes will be honored. Staffing Staff members trained and/or certified to perform for Health Care Providers will be present to provide for those residents electing a full code status. These certified team members shall provide until ordered to cease by an authorized, licensed physician, arrives to assume care, or the resident's , and are assessed as present. certification staffing will be reviewed as indicated. Procedure for initiating 1. Upon identification that the resident is	N 201		

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N 201	Continued From page 9 unresponsive, the person making the identification will check for , and , , and immediately call for help; loudly calling Code Blue and Room (#). 2. Staff will respond to room with medical record and emergency cart. 3. Chart will be checked for code status and if resident is a full code will be initiated. Once is started, will continue until: Relieved by Relieved by another staff member who will take over or Physician Orders to discontinue ; or Resident and , are , , /observable 4. One person will assign task: a. Bring emergency cart and chart b. Provide c. Call 911 d. Designate a scribe , use the code blue worksheet to notate timeline and activity, transcribe notes from worksheet to medical record upon resolution of event. e. Notify physician and resident representative f. Prepare paperwork for transfer to hospital g. Await and escort to the resident 5. Assist with transfer of resident to gurney for transport 6. Complete paperwork to include but may not be limited to 24-hour and nurses' notes. 7. Notify the NHA and DON. 8. Replenish emergency cart. According to American association, https:// , . . .org/en/resources/what-is- , "The 6 links in the adult out-of-hospital Chain of Survival" (accessed on at 2:30 p.m.): 1. Recognition of and	N 201		

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N 201	Continued From page 10 activation of the emergency response system (calling -1 in the US) 2. Early with an emphasis on 3. Rapid 4. Advanced by Emergency Medical Services and other healthcare providers 5. Post- care 6. Recovery (including additional treatment, observation, rehabilitation, and support) A strong Chain of Survival can improve chances of survival and recovery for victims of "Top 10 Take-Home Messages for Adult Life Support 1. On recognition of a event, a layperson should , and promptly activate the emergency response system and initiate ( )." Class I	N 201		

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F 000	INITIAL COMMENTS A complaint survey for complaint number 2021011095, in conjunction with a Focused Control visit, was conducted on , and continued through at Regents Park of Jacksonville. The complaint was substantiated, and the facility was not in compliance with 42 CFR 483, Requirements for Long-Term Care Facilities. This is a 120-bed facility with a census of 91 residents on . Immediate Jeopardy (IJ) was identified at F678 and F726. An extended survey was conducted. 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. Immediate Jeopardy at a scope and severity of J ( ) was identified at 12:24 p.m. on . The IJ was a result of the facility's failure to ensure Agency clinical staff understood how to respond to an unresponsive resident and provide basic life support, including , , ( ), as per the resident's Advance Directives and the facility's policies and procedures. Two Agency licensed practical nurses (LPNs) failed to verify Resident #1's code status after finding the resident unresponsive, and before initiating . The emergency medical response ( ) team was never notified, was stopped, and Resident #1 in the facility.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2021

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 On at 3:16 a.m., the Immediate Jeopardy began. On at 4:45 p.m. the Administrator was notified of the IJ determination. Immediate Jeopardy was removed upon survey exit on , effective . The facility remains out of compliance, and the scope and severity were reduced to "D", no actual harm, with a potential for no more than minimal harm, due to the facility's failure to provide Resident #1 the opportunity to be . The facility failed to ensure staff knew how to respond to an unresponsive resident, and provide basic life support, including , as per the resident ' s Advance Directives and the facility ' s policies and procedures. .	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 interviews and record reviews, the facility failed to ensure Agency clinical staff appropriately provided basic life support, including , ( ) to a resident (#1) requiring such emergency care, out of three residents reviewed, by failing to 1)	F 678	A. As resident is no longer residing in facility a record review of Resident #1 was performed on , by ADON. A complete and thorough Investigation was initiated and completed, and facility reported investigative findings as required.	

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REGENTS PARK OF JACKSONVILLE	8700 A C SKINNER PARKWAY JACKSONVILLE, FL 32256

(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) COMPLETION DATE
F 678	Continued From page 2 Verify the resident's code status prior to initiating , 2) Call emergency medical services ( ), and 3) Follow the facility's policy and procedure for : Code Status Orders and Response. On at 3:16 AM, Certified Nursing Assistant (CNA) B found Resident #1 unresponsive in bed. The resident was not breathing but was warm with coming from his . CNA B immediately summoned Agency Licensed Practical Nurse (LPN) C, who summoned Agency LPN A (the resident's assigned nurse) to the resident's room. was initiated by these two nurses without first checking the resident's code status. At 3:30 a.m., Agency LPN A left the room to check the resident's code status while Agency LPN C continued . Resident #1 was a full code status. Registered Nurse (RN) D was summoned and was met by Agency LPN A at the nurses' station at 3:36 a.m. Without assessing Resident #1, RN D instructed Agency LPN A to check Resident #1's chart, start , and call the physician and family. She further stated if Agency LPNs A and C could not obtain a , , the resident was and there was no need to call . RN D did not assist with or call herself. was never called. At 3:37 a.m., Agency LPN A notified the on-call Advanced Practice Registered Nurse (APRN) that had been stopped and Resident #1 expired. Immediate Jeopardy (IJ) at a scope of J ( ) was identified at 12:24 p.m. on . On at 3:16 a.m., the Immediate Jeopardy (IJ) began. On at 4:45 p.m., the Administrator was	F 678	Current residents were validated on by DON & SSD to ensure advanced directives were honored. No Concerns noted. B. An initial audit was completed on of current resident code statuses then again on by DON/Designee to ensure accuracy and advance directives were honored. No concerns identified. C. Licensed nursing staff were re-educated by the DON/designee on Advanced Directive P&P, Commitment to honoring advanced directive attestation, Code Status Orders and Response, Nurse Supervision, and code blue drills were conducted for competency. The education was completed by nursing administration by . Newly hired licensed nurses will be educated on the same. Code Blue Documentation will be reviewed 5 times a week in Clinical Meeting to ensure residents advanced directive were honored. Any issues identified during the meeting will be addressed at that time. D. Weekly audits of staff understanding of education will be conducted by the DON/designee for 4 weeks, then monthly x 2. These audits will be presented to Quality Assurance Meeting x 3 months or until substantial compliance by the director of nursing for review and revision of the current audit plan.	

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notified of the IJ determination, and immediate jeopardy was removed upon survey exit on , effective .

The facility remained out of compliance, and the scope and severity were reduced to "D".

On , the facility's census was 91. Any residents whose Advance Directives indicated a Full Code Status were at risk. There were 61 residents who had a Full Code status at that time.

The findings include:

Cross reference F726

A review of Resident #1's medical record revealed an admission on and a primary diagnosis of wasting and atrophy. Secondary diagnoses included , (fast rate), atherosclerotic (build-up in blocking flow), (blocked ,) and (clot) of other specified veins, novel coronavirus COVID-19, and ( ). The resident's discharge was noted as , and his physician's orders included full . The Admission Minimum Data Set (MDS) assessment, dated , indicated that the resident had a ( ) score of 15 out of a possible 15 points, indicating intact cognition. Resident #1 required with bed mobility and toilet use, limited assistance with transfers, and was independent with set-up for meals. His care plan for Advance

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Directives indicated the resident's wish to be a Full Code should he become unresponsive.

An interview was conducted with the Regional Director of Risk Management on [redacted] at 11:05 a.m. regarding the resident's discharge. She confirmed that there was no documentation about his discharge, therefore information was obtained from the facility's investigation of the [redacted] event. She provided the following timeline:

On [redacted] during routine rounding at 3:16 a.m., CNA B observed Resident #1 in his bed with is [redacted], closed and [redacted] coming out of his [redacted]. He was not breathing and his overall color was "different". Previous rounding conducted at 1:55 a.m. revealed the resident was still warm to the touch. CNA B summoned for a nurse and Agency LPN C came to the room. While donning personal protective equipment (PPE) to get into the COVID-19 unit, she contacted Agency LPN A (primary nurse assigned to Resident #1), who was on break, to come to the unit. Upon entering the resident's room at 3:17 a.m., Agency LPN A assessed Resident #1. After determining that the resident had no [redacted], she initiated [redacted]. Agency LPN C then asked CNA B to get linen to clean the resident. At around 3:18 a.m., Agency LPN A (primary nurse), entered the room and assisted Agency LPN C with [redacted]. After five minutes, Agency LPN C took over [redacted] again and asked Agency LPN A to check the resident's chart and confirm the code status. As Agency LPN C continued with [redacted], she contacted Registered Nurse (RN Supervisor) D over her personal phone via SIRI (voice-activated personal assistant that is part of Apple Inc.'s iOS, iPadOS, watchOS, macOS, and tvOS operating systems)

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to come to the unit, as there was an incident. RN D, who was on lunch break, was not provided with any details about which unit or room number Agency LPN C was referring to. When RN D arrived on the unit at approximately 3:25 a.m., she did not find anyone at the nurses' station and proceeded to care for her assigned resident. At 3:30 a.m., Agency LPN A went to the nurses station to verify Resident #1's code status. She noted that Resident#1 was a Full Code. She did not call . . or overhead page "Code Blue" per the facility's policy and procedure. She notified Agency LPN C that Resident #1 was a Full Code and to continue . At 3:36 a.m., RN D returned to the nurses' station from her assigned resident's room and found Agency LPN A there. Agency LPN A notified RN D that Resident #1 was unresponsive. RN D asked Agency LPN A to note the resident's time of . . . and contact the family and physician. RN D stated there was no need to contact . . , as the resident had . . . .

In a telephone interview on . . . at 12:40 p.m, CNA B stated Resident #1 was on the COVID unit. When she went to check his vital signs, she noted that he "was not himself" and had . . . . . coming from his . . . . . He was warm to the touch. She summoned for the nurse on the non-COVID unit (LPN C), as she could not locate the nurse on the COVID unit (Agency LPN A). Agency LPN C responded. While donning PPE to enter the COVID unit, Agency LPN C contacted Agency LPN A, the nurse assigned to the COVID unit. Moments after that, Agency LPN C assessed the resident and initiated . . . She then asked CNA B to get supplies to clean the resident's oral . . . . . CNA B left the room to get supplies. She stated she had to get the linen from a different nursing unit. CNA B added that

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she did "not even know" the resident was a full code, as the nurses were slow to act and did not announce "Code Blue" on the overhead paging system. She said when she returned to the COVID unit, the nurses had already stopped and she cleaned the resident. CNA B could not recall the time she returned to the unit.

In a telephone interview on at 12:44 p.m., Agency LPN A stated she could not remember the incident exactly. She mentioned that she provided the facility with a statement about the incident and stated that a copy could be obtained. (Copy obtained) Agency LPN A confirmed that she did not call per the protocol. She stated RN D told her there was no need to call if the resident was When Agency LPN A was asked whether RN D assessed Resident #1 in order to make this determination, Agency LPN A stated "no". At that time, Agency LPN A abruptly ended the interview.

On at 1:30 p.m., the Regional Director of Risk Management was interviewed. She stated she helped conduct the facility's investigation, and the nurses involved did not follow the facility's policy for Code Response. She added that in the event a resident was found unresponsive, the staff were expected to page Code Blue overhead with a room number, and designate one person to oversee the process, including calling while others performed , . She confirmed the staff did not do any of the above. RN D/RN Supervisor, did not help the nurses with the or assess the resident. She added that the facility had enough staff working that night, but they were not aware of the incident, as Agency LPNs A and C did not page Code Blue overhead or call . They also failed to document the

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F 678	Continued From page 7 event. During a telephone interview with the APRN on at 2:10 p.m., she stated she was on call the night of . . . . Facility staff paged her stating [Resident #1] had expired. She stated she called right . . to acknowledge she had received the page. Staff did not ask her whether they should stop . . She was not familiar with the resident, and was not aware that the resident was a full code, so she told the staff she would relay the information to the attending physician. In a telephone interview on at 3:30 p.m., the Medical Director (the resident's physician) stated he was notified of the incident the following morning by the on-call APRN. The APRN told him that staff notified her the resident had expired, but she was not informed that the resident was a full code. When asked his expectations on such a scenario, he stated he was not sure why the staff did not call to honor the resident's wishes. He added that [Resident #1] was his patient, and it was a " to hear of his . . . .". A review of the facility's policy and procedure titled : Code status Orders and Response (Effective ,) revealed: Policy - The facility provides Basic Life Support (BLS) . only. The physician's orders for full code or are written based on the wishes of the resident/resident representative. Advance Directives will be honored. On admission Staff will verify the presence of Advanced	F 678		

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Directives documents and confirm resident or resident representative wishes with regard to . . The resident will be considered a full code unless the resident/representative wishes to change their decision.
1. Obtain advanced directives decision making documents at the time of admission. If not available at time of admission, request the resident representative to bring a copies to the facility as soon as possible.
2. Discuss Code preference with the resident/resident representative.
3. Document resident/resident representative preferences in the medical record if the resident's wishes are different than the admission orders or if the orders do not address the code status, and the resident does not want to receive , staff will document resident's wishes in the record and contact the physician to obtain the order.
4. Notify physician if the resident/resident representative preferences change, and obtain order. In the event that the physician is not available, the Medical Director may be contacted for the order.
5. While awaiting the physician's order to withhold , the facility should document discussion with the resident/representative's verbalized wish to refuse . If the resident or resident representative verbalizes the wish not to receive , two staff members will witness and document this request. The conversation of the request will be printed and placed as the first document of the medical record.
a. While the physician's order is pending, staff will honor the documented verbal wishes of the resident or the resident's representative regarding . .

Quarterly/ PRN
1. Review and discuss code status with the

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resident/resident representative and confirm code status is unchanged. Document wishes are unchanged in the medical records.
2. If resident or resident representative wishes to change status, document in the record and notify physician to obtain the order.
6. Social Services and/or nursing should discuss Advance Directive decision with the resident/resident representative to ascertain that the resident/resident representative understands the decision.
7. Notify attending MD of the resident/resident representative request for or Full Code status. Residents' wishes will be honored.

Staffing
Staff members trained and/or certified to perform for Health Care Providers will be present to provide for those residents electing a full code status. These certified team members shall provide until ordered to cease by an authorized, licensed physician, arrives to assume care, or the resident's , and , are assessed as present.
certification staffing will be reviewed as indicated.
Procedure for initiating
1. Upon identification that the resident is unresponsive, the person making the identification will check for , and , , and immediately call for help; loudly calling Code Blue and Room (#).
2. Staff will respond to room with medical record and emergency cart.
3. Chart will be checked for code status and if resident is a full code will be initiated.
Once is started, will continue until:
Relieved by
Relieved by another staff member who will take over or

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Physician Orders to discontinue ; or
Resident and , are
/observable
4. One person will assign task:
a. Bring emergency cart and chart
b. Provide
c. Call 911
d. Designate a scribe
, use the code blue worksheet to notate timeline and activity, transcribe notes from worksheet to medical record upon resolution of event.
e. Notify physician and resident representative
f. Prepare paperwork for transfer to hospital
g. Await and escort to the resident
5. Assist with transfer of resident to gurney for transport
6. Complete paperwork to include but may not be limited to 24-hour and nurses' notes.
7. Notify the NHA and DON.
8. Replenish emergency cart.

According to American association, https:// .org/en/resources/what-is- , "The 6 links in the adult out-of-hospital Chain of Survival" (accessed on at 2:30 p.m.):
1. Recognition of and activation of the emergency response system (calling -1 in the US)
2. Early with an emphasis on
3. Rapid
4. Advanced by Emergency Medical Services and other healthcare providers
5. Post- care
6. Recovery (including additional treatment, observation, rehabilitation, and , support)

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F 678	Continued From page 11 A strong Chain of Survival can improve chances of survival and recovery for victims of " "Top 10 Take-Home Messages for Adult Life Support 1. On recognition of a event, a layperson should , and promptly activate the emergency response system and initiate ( )." The facility provided their immediate jeopardy removal plan, and these immediate actions were verified as having been completed by the surveyor on as follows: * The Administrator ensured the staff involved in the event were suspended on pending investigation and outcome. The facility employees were terminated and the Agency staff were not permitted in the facility effective * Agency and Facility staff must complete education prior to working. This began on . The Staff Development Coordinator (SDC) to conduct the education and the Nurse Supervisor to conduct education during off hours and weekends. Education packet to be provided to the Administrator daily for review. The Administrator to maintain a tracking log for Agency staff to ensure orientation is completed. Agency staff education began on on the following : Advanced Directives (post-test) Commitment to honoring advanced directive attestation Notification of change neglect , mistreatment of Resident/patient, misappropriate of resident	F 678		

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F 678	Continued From page 12 property (post-test) Code status orders and response Nurse supervision responsibilities 100% compliance achieved by * NHA education on job description was provided by the Regional Nurse Consultant by . . . . . * On the Regional Nurse Consultant completed the nurses' license verification and verified accuracy of the employee roster for the involved parties. * The Regional Nurse Consultant validated certification status for all nurses on . . . . with no concerns identified. * The Regional Nurse Consultant validated the Advance Directives attestation for all licensed staff with 100% compliance achieved by . . . . . * Code Blue drills with all staff including new and temporary staff were conducted at the beginning of their shifts on . Drills continued daily for one week and then two times weekly for four weeks to confirm all clinical staff understood the required process and response to honor Advance Directives. * Following the incident, the facility had two actual Code Blues and no concerns were identified. * An ad hoc quality assurance meeting was held to discuss QAPI (Quality Assurance and Performance Improvement) on . . . . . Corrective actions related to this incident will be discussed in QAPI meetings until total compliance is achieved.	F 678		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		

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F 726	Continued From page 13 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and , , well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure Agency and facility clinical staff had competencies and skills sets for appropriately providing basic life support, including . . . . , ... , ... (.) to a Resident (#1) requiring such emergency care, out of three residents reviewed. The facility failed	F 726	A. As resident is no longer residing in facility a record review of Resident #1 was performed on . . . . . by ADON. A complete and thorough Investigation and suspension of licensed nurses was completed. B. An audit was completed on . . . . . of	

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F 726	Continued From page 14 to ensure Agency and facility staff knew to 1) Verify the resident's code status prior to initiating , 2) Call emergency medical services ( ), and 3) Follow the facility's policy and procedure for : Code Status Orders and Response. On at 3:16 AM, Certified Nursing Assistant (CNA) B found Resident #1 unresponsive in bed. The resident was not breathing but was warm with coming from his . CNA B immediately summoned Agency Licensed Practical Nurse (LPN) C, who summoned Agency LPN A (the resident's assigned nurse) to the resident's room. was initiated by these two nurses without first checking the resident's code status. At 3:30 a.m., Agency LPN A left the room to check the resident's code status while Agency LPN C continued . Resident #1 was a full code status. Registered Nurse (RN) D was summoned and was met by Agency LPN A at the nurses' station at 3:36 a.m. Without assessing Resident #1, RN D instructed Agency LPN A to check Resident #1's chart, start , and call the physician and family. She further stated if Agency LPNs A and C could not obtain a , , the resident was and there was no need to call . RN D did not assist with or call herself. was never called. At 3:37 a.m., Agency LPN A notified the on-call Advanced Practice Registered Nurse (APRN) that had been stopped and Resident #1 expired. Immediate Jeopardy (IJ) at a scope of J ( ) was identified at 12:24 p.m. on . On at 3:16 a.m., the Immediate Jeopardy (IJ) began.	F 726	current resident code statuses, by DON/Designee to ensure accuracy and advance directives were honored. No concerns identified C. Agency staff education is being completed by the DON/Designee prior to working. Education includes Code Status Order and Response: Code Blue Process Advanced Directive P&P, Commitment to honoring advanced directive attestation, Code Status Orders and Response, and Nurse Supervision. This education completed by . Current and newly hired licensed nurses will be educated on the same. Agency Orientation Log will be reviewed 5 times a week by NHA Designee to ensure Agency Staff Educated prior to working. Any issues identified during the review will be addressed at that time. D. Weekly audits of staff understanding of education via post-test and return demonstration competencies will be conducted by the DON/designee for 4 weeks, then monthly x 2 with results brought to the monthly Quality Assurance Meeting x 3 months or until substantial compliance for review and revision of current audit plan.	

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F 726	Continued From page 15 On at 4:45 p.m., the Administrator was notified of the IJ determination, and immediate jeopardy was removed upon survey exit on , effective . The facility remained out of compliance, and the scope and severity were reduced to "D". On , the facility's census was 91. Any residents whose Advance Directives indicated a Full Code Status were at risk. There were 61 residents who had a Full Code status at that time. The findings include: Cross reference F678 A review of Resident #1's medical record revealed an admission on and a primary diagnosis of wasting and atrophy. Secondary diagnoses included , (fast rate), atherosclerotic (build-up in blocking flow), (blocked ,) and (clot) of other specified veins, novel coronavirus COVID-19, and ( ). The resident's discharge was noted as , and his physician's orders included full . The Admission Minimum Data Set (MDS) assessment, dated , indicated that the resident had a ( ) score of 15 out of a possible 15 points, indicating intact cognition. Resident #1 required with bed mobility and toilet use, limited assistance with transfers, and was independent with set-up for meals. His care plan for Advance	F 726		

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Directives indicated the resident's wish to be a Full Code should he become unresponsive.

An interview was conducted with the Regional Director of Risk Management on . . . . . at 11:05 a.m. regarding the resident's discharge. She confirmed that there was no documentation about his discharge, therefore information was obtained from the facility's investigation of the . . . . . event. She provided the following timeline:

On during routine rounding at 3:16 a.m., CNA B observed Resident #1 in his bed with is , closed and coming out of his . . . . . He was not breathing, and his overall color was "different". Previous rounding conducted at 1:55 a.m. revealed the resident was still warm to the touch. CNA B summoned for a nurse and Agency LPN C came to the room. While donning personal protective equipment (PPE) to get into the COVID-19 unit, she contacted Agency LPN A (primary nurse assigned to Resident #1), who was on break, to come to the unit. Upon entering the resident's room at 3:17 a.m., Agency LPN A assessed Resident #1. After determining that the resident had no , , she initiated . . . Agency LPN C then asked CNA B to get linen to clean the resident. At around 3:18 a.m., Agency LPN A (primary nurse), entered the room and assisted Agency LPN C with . . , ... After five minutes, Agency LPN C took over , . . again and asked Agency LPN A to check the resident's chart and confirm the code status. As Agency LPN C continued with . . , ... , she contacted Registered Nurse (RN Supervisor) D over her personal phone via SIRI to come to the unit, as there was an incident. RN D, who was on lunch break, was not provided with any details about

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which unit or room number Agency LPN C was referring to. When RN D arrived on the unit at approximately 3:25 a.m., she did not find anyone at the nurses' station and proceeded to care for her assigned resident. At 3:30 a.m., Agency LPN A went to the nurses' station to verify Resident #1's code status. She noted that Resident#1 was a Full Code. She did not call or overhead page "Code Blue" per the facility's policy and procedure. She notified Agency LPN C that Resident #1 was a Full Code and to continue . At 3:36 a.m., RN D returned to the nurses' station from her assigned resident's room and found Agency LPN A there. Agency LPN A notified RN D that Resident #1 was unresponsive. RN D asked Agency LPN A to note the resident's time of and contact the family and physician. RN D stated there was no need to contact , as the resident had .

In a telephone interview on at 12:44 p.m., Agency LPN A stated she could not remember the incident exactly. She mentioned that she provided the facility with a statement about the incident and stated that a copy could be obtained. (Copy obtained) Agency LPN A confirmed that she did not call per the protocol. She stated RN D told her there was no need to call if the resident was . When Agency LPN A was asked whether RN D assessed Resident #1 in order to make this determination, Agency LPN A stated "no". At that time, Agency LPN A abruptly ended the interview.

On at 1:30 p.m., the Regional Director of Risk Management was interviewed. She stated she helped conduct the facility's investigation, and the nurses involved did not follow the facility's policy for Code Response. She added that in the

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event a resident was found unresponsive, the staff were expected to page Code Blue overhead with a room number, and designate one person to oversee the process, including calling while others performed . She confirmed the staff did not do any of the above. RN D/RN Supervisor, did not help the nurses with the or assess the resident. She added that the facility had enough staff working that night, but they were not aware of the incident, as Agency LPNs A and C did not page Code Blue overhead or call . They also failed to document the event. When asked about Agency staff orientation, she stated each Agency staff member was supposed to receive an orientation packet before the beginning of their first shift. She confirmed that the facility did not check the Agency staff for competency prior to their providing care for the facility's residents.

In an interview on at 9:35 a.m., the Administrator confirmed that prior to the incident on , the facility did not have a plan in place for ensuring that Agency staff completed the orientation packet training prior to the start of their first shift. She stated the Staff Development Coordinator (SDC) was responsible for the staff training, but the facility has had no SDC since . The Director of Nursing (DON) was covering the position in the interim, but was on leave. When asked about the training provided to the Agency staff, the Administrator stated they were provided with a package containing different training topics and post-tests. She confirmed that the facility did not provide competency check offs for the Agency staff.

During an interview on at 11:31 a.m., Agency Licensed Practical Nurse (LPN) E stated

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her onboarding process in [redacted], included completing an orientation packet. She stated the packet was provided to her to complete and return after completion. She stated it was not mandatory to complete the training, and she could not remember whether she ever returned that packet to the facility. However, on [redacted], she was required to complete another packet and submit it to the SDC. When asked if she had completed any competencies prior to working with the residents at the facility, she answered, "No".

On [redacted] at 4:30 p.m., Agency CNA F stated she began working at the facility "on and off since [redacted]". She denied being given an orientation packet with training to complete upon hire. She stated she had not completed an orientation competency check either. She added that the facility notified her on [redacted], that she had to complete mandatory training which included facility policies and procedures as well as [redacted]/neglect training.

A review of the facility's policy and procedure titled [redacted]: Code status Orders and Response (Effective [redacted]) revealed:
Policy -
The facility provides Basic Life Support (BLS) [redacted] only. The physician's orders for full code or [redacted] are written based on the wishes of the resident/resident representative. Advance Directives will be honored.

On admission
Staff will verify the presence of Advanced Directives documents and confirm resident or resident representative wishes with regard to [redacted]. The resident will be considered a full code

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F 726	Continued From page 20 unless the resident/representative wishes to change their decision. 1. Obtain advanced directives decision making documents at the time of admission. If not available at time of admission, request the resident representative to bring a copy to the facility as soon as possible. 2. Discuss Code preference with the resident/resident representative. 3. Document resident/resident representative preferences in the medical record if the resident's wishes are different than the admission orders or if the orders do not address the code status, and the resident does not want to receive , staff will document resident's wishes in the record and contact the physician to obtain the order. 4. Notify physician if the resident/resident representative preferences change, and obtain order. In the event that the physician is not available, the Medical Director may be contacted for the order. 5. While awaiting the physician's order to withhold , the facility should document discussion with the resident/representative's verbalized wish to refuse . If the resident or resident representative verbalizes the wish not to receive , two staff members will witness and document this request. The conversation of the request will be printed and placed as the first document of the medical record. a. While the physician's order is pending, staff will honor the documented verbal wishes of the resident or the resident's representative regarding . Quarterly/ PRN 1. Review and discuss code status with the resident/resident representative and confirm code status is unchanged. Document wishes are unchanged in the medical records.	F 726		

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2. If resident or resident representative wishes to change status, document in the record and notify physician to obtain the order.
6. Social Services and/or nursing should discuss Advance Directive decision with the resident/resident representative to ascertain that the resident/resident representative understands the decision.
7. Notify attending MD of the resident/resident representative request for or Full Code status. Residents' wishes will be honored.

Staffing
Staff members trained and/or certified to perform for Health Care Providers will be present to provide for those residents electing a full code status. These certified team members shall provide until ordered to cease by an authorized, licensed physician, arrives to assume care, or the resident's , and are assessed as present.
certification staffing will be reviewed as indicated.
Procedure for initiating
1. Upon identification that the resident is unresponsive, the person making the identification will check for , and , , and immediately call for help; loudly calling Code Blue and Room (#).
2. Staff will respond to room with medical record and emergency cart.
3. Chart will be checked for code status and if resident is a full code will be initiated.
Once is started, will continue until:
Relieved by
Relieved by another staff member who will take over or
Physician Orders to discontinue ; or
Resident and , are /observable

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4. One person will assign task:
a. Bring emergency cart and chart
b. Provide
c. Call 911
d. Designate a scribe
, use the code blue worksheet to notate timeline and activity, transcribe notes from worksheet to medical record upon resolution of event.
e. Notify physician and resident representative
f. Prepare paperwork for transfer to hospital
g. Await and escort to the resident
5. Assist with transfer of resident to gurney for transport
6. Complete paperwork to include but may not be limited to 24-hour and nurses' notes.
7. Notify the NHA and DON.
8. Replenish emergency cart.

A review the Registered Nurse Job Description revealed:
Direct Care/Patient Responsibilities
Assess, plans, directs and evaluates total nursing care as determined by the resident's /patient 's age related physical, , and cultural needs in accordance with established standards, policies and procedures and residents/patients care plan.
Handles emergency situations in a prompt, precise and professional manner.
Performs as required.
Demonstrates an ability to remain calm, perform effectively and professionally during peak periods of activity and emergency situation.
Maintains accurate, detailed reports and records.
Reports all changes in residents' /patients' condition to the supervisor timely.

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A review the Licensed Practical Nurse Job Description revealed:
Direct Care/Patient Responsibilities
Supervises C.N.A staff as required
Assess, plans, directs and evaluates total nursing care as determined by the resident's /patient 's age related physical, [illegible] and cultural needs in accordance with established standards, policies and procedures and residents/patients care plan.
Handles emergency situations in a prompt, precise and professional manner.
Performs [illegible] as required.
Demonstrates an ability to remain calm, perform effectively and professionally during peak periods of activity and emergency situation.
Maintain accurate detailed reports and records.
Reports all changes in resident 's /patient's condition to the supervisor timely.

A review the Staff Development Coordinator Job Description revealed:
Summary of postion: The Staff Development Coordinator plans, organizes and coordinates all aspects of the program within the faclity. In addition, the Staff Develoment Coordinator plans, directs or coordinates the training and development activities for the staff at the faclity.
Essential Duties and Responsibilities:
Staff Development
Analyzing training needs to develop new training or modify and improve existing programs.
Conducts or arranges for ongoing technical training and personal development classes for staff members.
Conduct orientation sessions and arrange on-the-job training for new hires.
Coordinate established courses with the

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technical and professional courses provided by community schools and desigante training procedures.

The facility provided their immediate jeopardy removal plan, and these immediate actions were verified as having been completed by the surveyor on ... as follows:

* The Administrator ensured the staff involved in the event were suspended on pending investigation and outcome. The facility employees were terminated and the Agency staff were not permitted ... in the facility effective .

* Agency and Facility staff must complete education prior to working. This began on . The Staff Development Coordinator (SDC) to conduct the education and the Nurse Supervisor to conduct education during off hours and weekends. Education packet to be provided to the Administrator daily for review. The Administrator to maintain a tracking log for Agency staff to ensure orientation is completed. Agency staff education began on on the following :
Advanced Directives (post-test)
Commitment to honoring advanced directive attestation
Notification of change
neglect , mistreatment of
Resident/patient, misappropriate of resident property (post-test)
Code status orders and response
Nurse supervision responsibilities
100% compliance achieved by ...

* NHA education on job description was provided

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by the Regional Nurse Consultant by .
* On the Regional Nurse Consultant completed the nurses' license verification and verified accuracy of the employee roster for the involved parties.
* The Regional Nurse Consultant validated certification status for all nurses on with no concerns identified.
* The Regional Nurse Consultant validated the Advance Directives attestation for all licensed staff with 100% compliance achieved by .
* Code Blue drills with all staff including new and temporary staff were conducted at the beginning of their shifts on . Drills continued daily for one week and then two times weekly for four weeks to confirm all clinical staff understood the required process and response to honor Advance Directives.
* Following the incident, the facility had two actual Code Blues and no concerns were identified.
* An ad hoc quality assurance meeting was held to discuss QAPI (Quality Assurance and Performance Improvement) on .
Corrective actions related to this incident will be discussed in QAPI meetings until total compliance is achieved.

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