PRINTED: 09/15/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 41614 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8700 A C SKINNER PARKWAY REGENTS PARK OF JACKSONVILLE JACKSONVILLE, FL 32256 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 INITIAL COMMENTS N 000 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 emergency medical response (... .) team was was stopped, and Resident never notified. #1 . . . in the facility. The facility Administrator was notified of the Class I deficiency at 4:45 p.m. on

Electronically Signed

a.m.

practice:

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

The Class I deficiency began on

On ..., the facility's census was 91. The following is a description of the deficient

TITLE (X6) DATE

121

STATE FORM If continuation sheet 1 of 11 D7TS11

at 3:16

					PRINTED: 09/15/202 FORM APPROVE
Agency f	or Health Care Adminis	tration			FORWIAFFROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIJI TIRI F	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		Continuonos	COMPLETED
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41614			B. WING		08/13/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE	
DECEME	PARK OF JACKSONVIL	8700 A C	SKINNER PARI	KWAY	
REGENTA	PARK OF JACKSONVIL	JACKSO	WILLE, FL 322	256	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	4 (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	NATE DATE
				DEFICIENCY)	
N 201	Continued From page	1	N 201		
N 201	400 000(4)(0) E0 Di-		N 201		
SS=J			N ZU I		
30-0	Appropriate Health Ca	are			
		dequate and appropriate			
		ctive and support services,			
		es; mental health services,			
		ecreational activities; and			
		oilitative services consistent			
	with the resident care	plan, with established and			
	recognized practice s	tandards within the			
	community, and with	rules as adopted by the			
	agency.				
	This Statute or Rule	is not met as evidenced by:			
	Based on interviews a	and record reviews, the		A. As resident is no longer residing in	
	facility failed to provid	e adequate and appropriate		facility a record review of Resident #1	
		consistent with the resident		performed on by ADO	
		ized practice standards		complete and thorough Investigation v	
		by failing to ensure Agency		initiated and completed, and facility	
		tely provided basic life		reported investigative findings as requ	pired
		tely provided basic life		Current residents were validated on	
		f1) requiring such		by DON & SSD to ensure	
		of three residents reviewed.		advanced directives were honored. No	
					'
		nsure Agency clinical staff 1)		Concerns noted.	
	Verified the resident's			B. An initial audit was completed on	
		ed emergency medical		of current resident code	
		Followed the facility's		statuses then again on by	
	policy and procedure			DON/Designee to ensure accuracy an	ıd
	Orders and Response	e.		advance directives were honored. No	ŧ

AHCA Form 3020-0001

at 3:16 AM, Certified Nursing

.... CNA B immediately summoned

Assistant (CNA) B found Resident #1

breathing but was warm with

unresponsive in bed. The resident was not

summoned Agency LPN A (the resident's

assigned nurse) to the resident's room.

initiated by these two nurses without first

Agency Licensed Practical Nurse (LPN) C, who

checking the resident's code status. At 3:30 a.m.,

STATE FORM caso D7TS11 If continuation sheet 2 of 11

was

concerns identified.

C. Licensed nursing staff were

re-educated by the DON/designee on

Advanced Directive P&P, Commitment to

Code Status Orders and Response, Nurse

conducted for competency. The education

was completed by nursing administration

. Newly hired licensed nurses will

honoring advanced directive attestation.

Supervision, and code blue drills were

be educated on the same. Code Blue

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С

NAME OF PROVIDER OR SUPPLIER

B. WING __ STREET ADDRESS, CITY, STATE, ZIP CODE

41614

8700 A C SKINNER PARKWAY

REGENTS	PARK OF JACKSONVILLE	C SKINNER PAR SONVILLE, FL 32		
(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 201	Continued From page 2	N 201		
	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. Replistered 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 #15 chart, start , and call the physician and family. She further stated if Agency LPNs A and C could not obtain a		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.	
	A review of Resident #1's medical record revealed an admission on and a primary			

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С

B. WING _____

41614

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 DEFICIENCIE: (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY	(fast inition) (fast inition)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE		
	ON a boserved Resident #1 in his bed wid closed and coming out of losed and coming out of losed as not breathing and his over color was "different". Previous rounding conducted at 1:55 a.m. revealed the reside still warm to the touch. CNA B summoned nurse and Agency LPN C came to the roor While donning personal protective equipm (PPE) to get into the COVID-19 unit, she contacted Agency LPN A primary nurse as	th is his all ent was for a n. ent					

Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A.

A. BUILDING:	COMPLETED
	С
B. WING	08/13/2021

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REGENTS PARK OF JACKSONVILLE 10(4) ID 10(4) ID 11(5) PREFIX 11(6) PROVIDER'S PLAN OF CORRECTION 11(6) PREFIX 11(6) PREFIX 11(6) PREFIX 11(6) PROVIDER'S PLAN OF CORRECTION 11(6) PREFIX 11(6) PROVIDER'S PLAN OF CORRECTION	- 1					
DACKSONVILLE, FL. 32256 DACKSONVILLE, FL	8700 A C SKINNER PARKWAY					
PREFIX TAG PROPRIED TO THE APPROPRIATE PRECEDED BY FULL PREFIX REQUILATION FOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) 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	- 1					
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	ETE .					
around 3:18 a.m., Agency LPN A (primary nurse), entered the room and assisted Agency LPN C with						
Registered Nurse (RN Supervisor) D over her personal phone via SIRI (violos-aditivate) 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 funch 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'll 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 for her assigned resident's room and found Agency LPN A there. Agency LPN A other 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,						

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С

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B. WING _____

41614

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 FUI REGULATORY OR LSC IDENTIFYING INFORMATIC		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
N 201	Continued From page 5 CNA B stated Resident #1 was on the COVIC unit. When she went to check his vital signs, noted that he "was not himself" and had coming from his . He was v to the touch. She summoned for the nurse or non-COVID unit (LPN C), as she could not lot the nurse on the COVID unit (Agency LPN A) Agency LPN C responded. While donning PI to entire the COVID unit. Agency LPN C contains the covid page of the COVID unit. Agency LPN C contains a state that, Agency LPN C contains a season and the covid page of the COVID unit. Agency LPN C contains a season and the covid page of the COVID unit. Agency LPN C contains a season and the covid page of the COVID unit. And befit the rought state of the covid page of the covi	on the state of th	201				
	Risk Management was interviewed. She stat						

Agency for Health Care Adminis	tration		FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	41614	B. WING	C 08/13/2021

NAME OF P	ROVIDER OR SUPPLIER	STREET ADDR	ESS, CITY, STA	ITE, ZIP CODE			
REGENTS	PARK OF JACKSONVILLE		A C SKINNER PARKWAY SONVILLE, FL 32256				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIGIENCY)	(X5) COMPLETE DATE		
	Continued From page 6 she helped conduct the facility's investigation and the nurses involved did not follow the far policy for Code Response. She added that it event a resident was found unresponsive, the staff were expected to page Code Blue over with a room number, and designate one persoversee the process, including calling vollets and the staff were expected to page Code Blue over the staff did not do any of the above. RN DI Supervisor, did not help the nurses with the or assess the resident. She added that the facility had enough staff working that hight, they were not aware of the incident, as Agen LPNs A and C did not page Code Blue overhor call They also failed to document the event. During a telephone interview with the APRN at 2:10 p.m., she stated she was on the night of Facility staff paged her stating [Resident #1] had expired. She state she called right to acknowledge she ha received the page. Staff did not ask her whe they should stop. She was not familiar the resident, and was not aware that the resi was a full code, so she told the staff she wourelay the information to the attending physiciar stated he was notified of the incident the following the original process of the resident had expired. In a telephone interview on a 13:30 p. the Medical Director (the resident she was not familiar 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 a very head add that the added that hon or the resident's whead was the added that hon or the resident is whead the added that hon or the resident is whead the added that he ad	n, cility's n the e head son to head son to while med RN e e head son to call e e e e e e e e e e e e e e e e e e			DATE		
	[Resident #1] was his patient, and it was a " to hear of his ".				VALUE AND ADDRESS OF THE PARTY		

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С

NAME OF PROVIDER OR SUPPLIED

B. WING ____

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41614

AME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
POPUTO	EGENTS PARK OF JACKSONVILLE		8700 A C SKINNER PARKWAY						
EGENIA	S PARK OF JACKSONVILLE	JACKSON	VILLE, FL 32256	3					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMA'	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
N 201	Continued From page 7		N 201		A CONTRACTOR AND A CONT				
	A review of the facility's policy and procedu titled : Code status Orders and Respoi (Effective) revealed: Prolicy - The facility provides Basic Life Support (BL only. The physician's orders for full conly. The physician's orders for full wishes of the resident/resident representatil Advance Directives will be honored. On admission Staff will verify the presence of Advanced Directives documents and confirm resident resident representative wishes with regard . The resident will be considered a full unless the resident will be considered a full unless the resident/ferpresentative wishes to change their decision. 1. Obtain advanced directives decision modocuments at the time of admission, request the resident representative to bring a copies to facility as soon as possible. 2. Discuss Code preference with the resident/resident representative. 3. Document resident/resident represent preferences in the medical record if the res wishes are different than the admission ord if the orders on ot address the code status the resident does not want to receive will document resident/resident resident/resident representative preferences the code status the resident does not want to receive will document resident the physician in the resident/resident representative preferences the code status the resident was the code status the resident on the terminative preferences change, and ob order. In the event that the physician is not available, the Medical Director may be confort the order. 5. While awaiting the physician's order to	or to code o naking the attive staff rd and t tatatin tacted							

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING ____

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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41614

REGENTS	PARK OF JACKSONVILLE	SKINNER PARKWAY WILLE, 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 DEFIGIENCY)	(X5) COMPLETE DATE	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE	
	Staffmembers 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 residents, and are assessed as present. certification staffing will be reviewed as indicated. Procedure for initiating. Upon identification that the resident is				

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING ___

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

41614

8700 A C SKINNER PARKWAY

REGENTS	PARK OF JACKSONVILLE	SKINNER PARKV VILLE, 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)	(XS) COMPLETE DATE
N 201	Continued From page 9 unresponsive, the person making the identification will check for 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 started, will continue until: Relieved by another staff member who will take over or Physician Orders to discontinue or resident and are physician orders to discontinue or resident and activity, transcribe notes from worksheet to medical record upon resolution of event. Designate a scribe order or resolution of event. Notify physician and resident representative or Notify physician and resident representative or event. According to American association, https://p.co.green/resources/what-is- Notify the NHA and DON. Replenish emergency cart.	N 201		

PRINTED: 09/15/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 08/13/2021 41614 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8700 A C SKINNER PARKWAY REGENTS PARK OF JACKSONVILLE JACKSONVILLE, FL 32256 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 Continued From page 10 N 201 activation of the emergency response system (calling -1 in the US) 2. Early . with an emphasis on 4. Advanced by Emergency Medical Services and other healthcare providers 5. Postcare 6. Recovery (including additional treatment, observation, rehabilitation, and A strong Chain of Survival can improve chances of survival and recovery for victims of "Top 10 Take-Home Messages for Adult Life Support On recognition of a event, a layperson should ..., and promptly activate the emergency response system and initiate ()." Class I

PRINTED: 00/15/2021

		ID HUMAN SERVICES MEDICAID SERVICES						M APPROVED
	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(9/2) 84111	PLE CONS		(X3) DATE	0. 0938-0391	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		HRUCHON			PLETED
			A. BUILDIN				l .	С
		105533	B. WING				l .	
NAME OF B	ROVIDER OR SUPPLIER	100000	1	етреет	ADDRESS, CITY, STATE, ZIP CODE	:	1 08/	13/2021
MANUE OF TH	NOVIDER OR SUFFEIER				C SKINNER PARKWAY	-		
REGENTS PARK OF JACKSONVILLE					ONVILLE, FL 32256			
010.10	CI BAMADY CT.	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF COR	DECTION		(3(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		COMPLETION DATE
F 000	INITIAL COMMENTS		FO	100				
		nction with a Focused was conducted on ,						
	was not in compliance	abstantiated, and the facility e with 42 CFR 483, g-Term Care Facilities.						
	This is a 120-bed fact residents on .	lity with a census of 91						
		(IJ) was identified at F678 led survey was conducted.						
	provider's noncomplia	ised, or is likely to cause,						
	() was identificated by the same of the s	as per the resident's nd the facility's policies and sney licensed practical to verify Resident #1's code a resident unreponsive, and The emergency medical to was never notified.						

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

(X6) DATE /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.

Electronically Signed

PRINTED: 09/15/2021

		ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES	1				0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				LETED
		105533	B. WING				0 13/2021
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DECENTS	PARK OF JACKSONVIL	15		87	00 A C SKINNER PARKWAY		
REGENTS	FARK OF JACKSONVIL	LE		JA	ACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ΒĒ	(X5) COMPLETION DATE
F 000	Continued From page	······	F	000			
	On at 3:16 a. began.	m., the immediate Jeopardy					
	notified of the IJ deter	ed upon survey exit on					
	scope and severity wharm, with a potential harm, due to the facility Resident #1 the opport The facility failed to e respond to an unresposic life support, incl	rtunity to be					
F 678 SS=J	CFR(s): 483.24(a)(3)		F	678			
	related physician orde advance directives.	, to a resident requiring prior to the arrival of ersonnel and subject to					
	Based on interviews facility failed to ensur appropriately provided including	and record reviews, the e Agency clinical staff d basic life support,,			A. As resident is no longer residing in facility a record review of Resident #1 performed on by ADO complete and thorough Investigation w initiated and completed, and facility	was N. A	

out of three residents reviewed, by failing to 1)

Facility ID: 41614

reported investigative findings as required.

PRINTED: 09/15/2021

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		105533	B. WING				13/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DECENTS	PARK OF JACKSONVIL	. =		8	700 A C SKINNER PARKWAY		
REGENTA	FARK OF JACKSONVIL	LE		J.	ACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 678	Verify the resident's c., 2) Call emerger and 3) Follow the faci for : Code Status Community of the communit	ode status prior to initiating toy medical services (), litty's policy and procedure or Orders and Response. M. Certified Nursing und Resident #1 The resident was not make the make	Fi	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 an advance directives were honored. No concerns identified. C. Licensed nursing staff were re-educated by the DON/Mesignee on Advanced Directive P&P, Commitmen honoring advanced directive etselves for expension, and code blue drill 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 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 understandin of education will be conducted by the DON/designee for 4 weeks, then mon X2. These audits will be presented to Quality Assurance Meeting to repsented to Quality Assurance Meeting to repsented to Quality Assurance Meeting x3 month until substantial compliance by the director of nursing for review and revis of the current audit plan.	d d t to n, s e e coe	
	initiated by these two checking the resident Agency LPN A left the resident's code status continued . Resistatus. Registered N. and was met by Agen station at 3:36 a.m. v #1, RN D instructed A Resident #1's chart, sphysician and family. LPNs A and C could resident was a new continued to the country of the	nurses without first 's code status. At 3:30 a.m., e room to check the while Agency LPN C deet #1 was a full code urse (RN) D was summoned or LPN at the nurses' Vithout assessing Resident gency LPN At the check tart _ and call the She further stated if Agency hot obtain a , _ the d there was no need to call ssist with _ or call _ ver called. At 3:37 a.m., d the order the control of the control			honoring advanced directive attestable Code Status Orders and Response. Nurse Supervision, and code blue drill were conducted for competency. The deducation was completed by nursing administration by	n, s e e pe l l ng s or	

On ... at 4:45 p.m., the Administrator was

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CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	405500	P MINE	С

105533 B. WING 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8700 A C SKINNER PARKWAY

JACKSONVILLE, FL 32256

		1	ACCIONALEE, I E CEESO	
(4) ID REFIX 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 3	F 678		
. 010		F 010		1
	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 section of Decident Hills we disclose			
	A review of Resident #1's medical record revealed an admission on and a primary			
	diagnosis of wasting and atrophy.			
	Secondary diagnoses included			
	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			
	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			1

REGENTS PARK OF JACKSONVILLE

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CENTERS FOR MEDICARE &	MEDICAID SEKVICES		ONID NO. 0930-033
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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CENTERS FOR MEDICARE & MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
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B. WING 105533 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITT, STATE, 21F GODE			
REGENTS PARK OF JACKSONVILLE		8700 A C SKINNER PARKWAY				
		١.	JACKSONVILLE, FL 32256			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
Continued From page 5 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	F	678				

PRINTED: 09/15/2021 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES STA AN

CENTERS FOR MEDICARE & MEDICAID SERVICES					
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	i i
DEGENTO DADA DE LA CACOMANA E		8700 A C SKINNER PARKWAY			
REGENTS PARK OF JACKSONVILLE			JACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI 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 6 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	F	678		

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CENTERS FOR MEDICARE & MEDICAID SERVICES (
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	105533	B. WING		08/13/2021	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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	the statement of the st		-		707 137 202 1	
NAME OF PROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE			
REGENTS PARK OF JACKSONVILLE			8700 A C SKINNER PARKWAY			
REGENTS PARK OF JACKSONVILLE			JACKSONVILLE, FL 32256			
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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 stafed 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 bold 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 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 was not sure why the staff did not call to honor the resident's was a "to hear of his"	F6	378			
	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					

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DELIARTIMENT OF REACTIONS	D HOWAIN OLIVIOLO		FORM APPROVE
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105533	B. WING	08/13/2021

08/13/2021 NAME OF PROVIDER OR SUPPLIER

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 8700 A C SKINNER PARKWAY JACKSONVILLE, FL 32256 ID PROVIDER'S PLAN OF CORRECTION		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLÉTION DATE	
F 678 Continued From page 8 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, request the resident representative to bring a copies to the facility as soon as possible. 2. Discuss Code preference with the resident/resident representative preferences with the 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 document everbelizes these of the resident or the resident	F 678			

1. Review and discuss code status with the

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ENTERS FOR MEDICARE & MEDICAID SERVICES C					
TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
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08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

8700 A C SKINNER PARKWAY REGENTS PARK OF JACKSONVILLE JACKSONVILLE, FL 32256 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)

F 678

F 678 Continued From page 9

AND

resident/resident representative and confirm code status is unchanged. Document wishes are unchanged in the medical records.

- If resident or resident representative wishes to change status, document in the record and notify physician to obtain the order. 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

for Health Care Providers will be present to for those residents electing a full code status. These certified team members shall provide until ordered to cease by an authorized, licensed physician. assume care, or the resident's . . . and are assessed as present.

Staff members trained and/or certified to perform

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 (#).
- Staff will respond to room with medical record and emergency cart.
- 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 FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D7TS11

Facility ID: 41614

If continuation sheet Page 10 of 26

		ID HUMAN SERVICES				FORM	0: 09/15/2021 MAPPROVED
ATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039* (X3) DATE SURVEY COMPLETED	
		105533	B. WING	_		ı	C 13/2021
	ROVIDER OR SUPPLIER PARK OF JACKSONVIL	LE		8	TREET ADDRESS, CITY, STATE, ZIP CODE 700 A C SKINNER PARKWAY ACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 678	timeline and activity, worksheet to medical event. e. Notify physician: f. Prepare paperworks, wasternessed and transport. G. Await and c. Complete papers be limited to 24-hour. T. Notify the NH4 a. 8. Replenish emerg. According to America https://org/e "The 6 links in the ad Survival" (accessed c. 1. Recognition of activation of the emer (calling 1 in the U. 2. Early with with with and with with and	iscontinue ; or are are assign task: cart and chart on the cart and chart on the eworksheet to notate transcribe notes from record upon resolution of and resident representative rick for transfer to hospital secort to the resident or of resident to gurney for work to include but may not and nurses' notes. In dook, lency cart. In association, riresources/what-is-ait out-of-hospital Chain of in at 2:30 p.m.): and gency response system S) an emphasis on	F	678			

6. Recovery (including additional treatment, observation, rehabilitation, and

PRINTED: 09/15/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES. ST

				FORWAFFROVE		
ENTERS FOR MEDICARE & MEDICAID SERVICES OI						
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
				С		
	105533	B. WING		08/13/2021		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 8700 A C SKINNER PARKWAY REGENTS PARK OF JACKSONVILLE JACKSONVILLE, FL 32256 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 678 Continued From page 11 F 678 A strong Chain of Survival can improve chances of survival and recovery for victims of "Top 10 Take-Home Messages for Adult Life Support On recognition of a layperson should , and promptly activate the emergency response system and initiate . . . , (. The facility provided their immediate ieopardy 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 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 mistreatment of neglect

Resident/patient, misappropriate of resident

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 09/15/2021 RM APPROVED IO: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DA3	(X3) DATE SURVEY COMPLETED	
		105533	B. WING _		0:	C 8/13/2021
	ROVIDER OR SUPPLIER PARK OF JACKSONVIL	LE		STREET ADDRESS, GITY, STATE, ZI 8700 A C SKINNER PARKWAY JACKSONVILLE, FL 32256	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFE TAG	PROVIDER'S PLAN: X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 678	property (post-test) Code status orders a Nurse supervision res 100% compliance aci * NHA education on j by the Regional Nurs * On the Reg completed the nurses evrified accuracy of t involved parties. * The Regional Nurse certification status for no concerns identified * The Regional Nurse Advance Directives a staff with 100% comp * Code Blue drills with temporary staff were of their shifts on for one week and the weeks to confirm all crequired process and Directives. * Following the incide Code Blues and no o * An ad hoc quality as to discuss QAPI (Que	and response sponsibilities nieved by bb description was provided e consultant by lonal Nurse Consultant! license verification and ne employee roster for the e Consultant validated all nurses on with disconsistent of all licensed lilance achieved by all staff including new and conducted at the beginning Drills continued daily in two times weekly for four three times weekly for four clinical staff understood the response to honor Advance in, the facility had two actual noncems were identified. Surrance meeting was held allity Assurance and ment) on attention to this incident will be eetings until total	Fe	578		
	Competent Nursing S CFR(s): 483.35(a)(3)		F:	726		

PRINTED: 09/15/2021

		ID HUMAN SERVICES					M APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES		_			OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		105533	B. WING			1	C 13/2021
NAME OF P	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE		
DECENTS	PARK OF JACKSONVIL	15		8	700 A C SKINNER PARKWAY		
REGENTS	FARE OF JACKSONVII	LLE		J	ACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F726	§483.35 Nursing Ser The facility must have appropriate comp provide nursing and resident safety and a practicable physical, well-being of each re resident safety and a practicable physical, well-being of each re resident assessments and considering the diagnoses of the facility and sill sets necess. needs, as identified it assessments, and de sassessments, and de the facility must ensit to demonstrate comp techniques necessar needs, as identified it assessments, and de This REQUIREMENT by: Based on interviews facility failed to ensur staff had competenci appropriately providir including.	vices sufficient nursing staff with eterncies and skills sets to elated services to assure titation or maintain the highest mental, and, sident, as determined by s and individual plans of care number, acutify and itly's resident population in acility assessment required citity must ensure that the specific competencies any to care for residents' nrough resident scribed in the plan of care. Ing care includes but is not evaluating, planning and at care plans and responding to or or or seidents' rough resident scribed in the plan of care. Ing care includes but is not evaluating, planning and at care plans and responding ty of nurse aides. In the through resident scribed in the plan of care. If is not met as evidenced and record reviews, the e Agency and facility clinical es and skills sets for g basic life support,	F	7726	A. As resident is no longer residing in facility a record review of Resident #1 performed on by ADO complete and thorough Investigation is suspension of licensed nurses was completed.	was N. A	

out of three residents reviewed. The facility failed

B. An audit was completed on of

PRINTED: 09/15/2021

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391
NO DEAN OF CODDECTION DESCRIPTION NUMBER.		(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105533	B. WING _			1	C /13/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				87	00 A C SKINNER PARKWAY		
REGENTS	PARK OF JACKSONVIL	LE		JA	ACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F726	to ensure Agency and Verify the resident's c., 2) Call emergei and 3) Follow the fac. for Code Status On at 3:16 Al Assistant (CNA) B for commendation of the	discility staff knew to 1) ode status prior to initiating now medical services (), tillty's policy and procedure of Orders and Response. M. Certified Nursing und Response. M. Certified Nursing und Resident #1 The resident was not remained the state of the sta	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 working. Education includes Code St. Order and Responses: Code Blue Proc Order and Responses: Code Blue Proc Order and Responses: Code Blue Proc Order and Responses: Advanced Directive P&P. Commitm to honoring advanced directive attestat Code Status Orders and Response, a Nurse Supervision. This education completed by Current and net hired licensed nurses will be educated the same. Agency Orientation Log will reviewed 5 times a week by NHA Designee to ensure Agency Staff Educated prior to working. Any issued identified during the review will be addressed at that time. D. Weekly audits of staff understandiof education is 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 Assura Meeting x 3 months or until substantia compliance for review and revision of current audit plan.	to atus beess eent tition, and why a on be	

		ID HUMAN SERVICES MEDICAID SERVICES			F	ORM APPROVED B NO. 0938-0391
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		105533	B. WING			C 08/13/2021
	ROVIDER OR SUPPLIER PARK OF JACKSONVIL	LE	,	STREET ADDRESS, CITY, STATE, ZIP CODE 8700 A C SKINNER PARKWAY JACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(XIS) COMPLETION DATE
F 726	notified of the IJ detein jeopardy was remove effective The facility remained scope and severity wood on the facility remained scope and severity wood the facility residents whose Advaries for the findings include: The findings include: Cross reference F678 A review of Resident revealed an admission of wood of the several control of the several cont	m., the Administrator was mination, and immediate d upon survey exit on out of compliance, and the are reduced to "D". y's census was 91. Any ince Directives indicated a sat risk. There were 61 "ull Code status at that time. #1's medical record in on and a primary wasting and atrophy. included in on and a primary wasting and atrophy. included in the properties of the provided of the provided in the provided i	F	726		

..... 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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ENTERS FOR MEDICARE & MEDICAID SERVICES O					
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
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	105533	B. WING	08/13/2021		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8700 A C SKINNER PARKWAY REGENTS PARK OF JACKSONVILLE JACKSONVILLE, FL 32256 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 726 Continued From page 16 F 726 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: 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 ., she contacted Registered Nurse (RN Supervisor) D over her personal phone via SIRI to come to the unit, as there was an incident. RND, who was on lunch break, was not provided with any details about

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CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
REGENTS	PARK OF JACKSONVILLE			700 A C SKINNER PARKWAY ACKSONVILLE, FL 32256	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFID TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 17 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 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 asked Agency LPN A not note the resident's time of as the resident had In a telephone interview on at 12:44 p.m., Agency LPN A stated she could not remember 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 conflict in a 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 abruptly ended the interview.	F7	226		
	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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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	T T	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER PARK OF JACKSONVIL	LE		STREET ADDRESS, CITY, STATE, Z 8700 A C SKINNER PARKWAY	IP CODE	
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F 726	event a resident was staff were expected to with a room number, oversee the process, others performed. The staff did not do an Supervisor, did not he or assess the residen cality had enough st they were not aware. LPNs A and C did not or call . They als event. When asked a crientation, she state was supposed to recommend that the fax agency staff for comproviding care for the In an interview on Administrator confirms on the facility place for ensuring the orientation packet their first shift. She se Coordinator (SDC) w training, but the facility had the specific place for ensuring the covering the position leave. When asked a the Agency staff, the were provided with a training topics and positions and the staining topics and positions are staff in the were provided with a training topics and positions.	found unresponsive, the page Code Blue overhead and designate one person to including calling while She confirmed by of the above. RN D/RN alp the nurses with the . t. She added that the aff working that night, but of the incident, as Agency page Code Blue overhead so falled to document the about Agency staff member sive an orientation packet of their first shift. She sillity did not check the evency prior to their facility's residents.	F	726		

for the Agency staff. During an interview on

at 11:31 a.m.,

Agency Licensed Practical Nurse (LPN) E stated

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEFAIL	VIEW OF HEALTHAN	ID HOMAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		105533	B. WING		C 08/13/2021
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
			8700	A C SKINNER PARKWAY	
REGENTS	PARK OF JACKSONVIL	LLE	JAC	KSONVILLE, FL 32256	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F726	her onboarding proceincluded completing is stated the packet was and return after commandatory to complete could not remember to that packet to the fac she was required to completed any completed and the residents at 1 "No". On at 4:30 p. she began working at 1 "No". She der orientation packet withing. She stated she orientation complete mandato facility policies and promised that the facility notifies to complete mandato facility policies and promised training. A review of the facility titled in Code state (Effective Policy - The facility provides to only. The physical shadows of the residen Advance Directives we On admission Statf will verify the principles.	iss in an orientation packet. She is provided to her to complete letion. She stated it was not te the training, and she whether she ever returned littly. However, on, complete another packet and When asked if she had etencies prior to working he facility, she answered, m., Agency CNA F stated the facility "on and off since ised being given an h training to complete upon had not completed an cy check either. She added dher on, that she had ry training which included ocedures as well as 9.9.9.9.9.9.9.9.9.9.9.9.9.9.9.9.9.9.9.	F 726		
	Staff will verify the pro-	esence of Advanced and confirm resident or we wishes with regard to			

. The resident will be considered a full code

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			FORW AFFROVE
CENTERS FOR MEDICARE & I	MEDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
			8700 A C SKINNER PARKWAY			
REGENTS	PARK OF JACKSONVILLE		J	JACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 receivestaff will document resident's wishes in the record and contact the physician is 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 withholdthe facility should document discussion with the resident/representative verbaitzed wish to refuse if the resident or resident representative verbaitzes 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 recyclent representative verbaitses of the resident representative reparding. Cuarterly/PRN 1. Review and discuss code status with the resident/resident representative and confirm code	F	726			

status is unchanged. Document wishes are unchanged in the medical records.

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ENTERS FOR MEDICARE & MEDICAID SERVICES C							
TEMENT OF DEFICIENCIES (X PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
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08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

REGENTS PARK OF JACKSONVILLE JACKSONVILLE, FL 32256 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 726 Continued From page 21 F 726 2. If resident or resident representative wishes to change status, document in the record and notify physician to obtain the order. 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. Notify attending MD of the resident/resident representative request for or Full Code status. Residents' wishes will be honored.

Staffing

AND

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 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. 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 Physician Orders to discontinue . ; or

are

and

Resident ./observable FORM CMS-2567(02-99) Previous Versions Obsolete

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CENTERS FOR MEDICARE & MEDICAID SERVICES C					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
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105533 B. WING 08/13/2021

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			8700 A C SKINNER PARKWAY		
REGENTS	PARK OF JACKSONVILLE		JACKSONVILLE, FL 32256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (XS) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)		
F 726	Continued From page 22 4. One person will assign task: a. Bring emergency cart and chart b. Provide c. C. Bill 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 resident/spatients care plan. Handles emergency situations in a prompt, performs as required. Demonstrates an ability to remain caim, perform fectively and professionally during peak periods of activity and emergency situation. Maintains accurate, detailed reports and records. Reports all changes in residents' /patients'	F7:	26		

condition to the supervisor timely.

PRINTED: 09/15/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING __

105533 B. WING 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

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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 (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F726	Continued From page 23 A review the Licensed Practical Nurse Job Description revealed: Direct Care/Patent Responsibilities Supervises C.N.A staff as required Assess, Janns, 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, policities 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. 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 facility. In addition, the Staff Development Coordinator plans, organizes and coordinates the rinning and development activities for the staff at the facility. Essential Duties and Responsibilities: Staff Development Analyzing training needs to develop new training and represent development exhibits Conditions 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.	F 72	6		

AND PLAN OF CORRECTION

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ENTERS FOR MEDICARE & MEDICAID SERVICES C							
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
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		105533	B. WING			08/13/20	21
NAME OF PE	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
DECENTS	PARK OF JACKSONVIL	16		8	700 A C SKINNER PARKWAY		
NEOLITO	TARREST CACROONING			٤	ACKSONVILLE, FL 32256		
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F 726	Continued From page	24 ional courses provided by	F:	726			
	community schools ar procedures.						
	the event were suspe investigation and outcomployees were term						
	(SDC) to conduct the Supervisor to conduct and weekends. Educ to the Administrator d.	king. This began on evelopment Coordinator education and the Nurse leducation during off hours ation packet to be provided aily for review. The					
	Administrator to main: Agency staff to ensure Agency staff educatio following:	e orientation is completed.					
	attestation Notification of change	ing advanced directive					
	neglect , Resident/patient, miss property (post-test) Code status orders as	mistreatment of appropriate of resident and response					
	Nurse supervision res 100% compliance act	ponsibilities					
	* NHA education on jo	b description was provided					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
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	105533	B. WING	08/13/2021			

8700 A C SKINNER PARKWAY

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

JACKSONVILLE, FL 32256 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 726 Continued From page 25 F 726 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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REGENTS PARK OF JACKSONVILLE