STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106074	A. Building B. Wing	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Kissimmee Gardens	1120 W Donegan Ave Kissimmee, FL 34741

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview and record review, the facility failed to honor advanced directives for a Do Not Resuscitate Order (DNRO) for 1 of 5 residents sampled for DNROs of a total of 17 residents residing in the facility with DNROs, (#1). This failure contributed to resident #1 receiving cardiopulmonary resuscitation (CPR) despite her explicit wish for a natural, dignified death and placed her at risk for serious injury / impairment / prolonged death. While resident #1 suffered resuscitation attempts including chest compressions, there was likelihood she experienced pain, broken bones, organ damage and a prolonged dying process. On [DATE] at approximately 6:00 AM, resident #1 suddenly became unresponsive at the Pebblestone unit nurses' station. Registered Nurse (RN) A transferred resident #1 to her bed while RN D went to request assistance from the Director of Nursing (DON). RN A applied oxygen to resident #1 for slow and shallow respirations and left resident #1 alone and returned to the nurses' station. When the DON arrived at the nurses' station, he was informed by RN A that resident #1 was a full code. The DON assessed resident #1 and when she stopped breathing and had no pulse, the DON instructed RN B to start CPR. A few minutes later, RN C informed the DON and RN B that the resident had a DNRO. The facility's failure to honor advance directives put all residents with a DNROs at risk. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed on [DATE]. The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not an Immediate Jeopardy after verification of the facility's immediate actions. Findings: Resident #1 was a [AGE] year-old, admitted to the facility on [DATE] with diagnoses of congestive heart failure and osteoarthritis. The Minimum Data Set (MDS) quarterly assessment with assessment reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status score of 9 which indicated moderately impaired cognition. The assessment revealed resident #1 received hospice services, was independently ambulatory and able to express her preferences. (continued on next page)

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

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 had a care plan initiated on [DATE] for advance directives related to a DNRO. The care plan goal read, Resident will have advanced directive followed. Review of resident #1's electronic medical record revealed a physician's order dated [DATE] for DNR status. A physician's progress note dated [DATE] included, Patient is DNR. Review of resident #1's electronic medical record revealed two copies of the form titled, State of Florida DO NOT RESUSCITATE ORDER that noted, Based upon informed consent, I the undersigned, hereby direct that CPR be withheld or withdrawn. The physician's statement read, I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation . from the patient in the event of the patient's cardiac or respiratory arrest. The document dated [DATE] was signed by resident #1's granddaughter and the physician. The updated DNRO dated [DATE] was signed by resident #1 and the physician. A Change in Condition form, dated [DATE] at 6:40 AM, read, Resident complaint of having a small discomfort in the back area and lost consciousness, did not respond. RN A noted interventions provided were oxygen and notification to 911. On [DATE] at 12:13 PM, RN A recalled on the morning of [DATE], resident #1 walked to the nurses' station using a walker and asked for coffee. RN A stated he noticed resident #1 did not look good and appeared to lose her balance. RN A said, She complained of back pain and passed out. I grabbed her. RN A explained he yelled to RN D that he needed help while he placed resident #1 in a nearby wheelchair and transported her to her room. RN A stated RN D did not accompany him to the room but rather ran from the unit to get assistance. On assessment, RN A stated the resident's respiratory rate was decreasing and her breathing was becoming shallow. RN A indicated he attempted to obtain vital signs but could not get a reading for either blood pressure or identify a pulse. He said he placed resident #1 on oxygen. RN A explained when the DON arrived on the Pebblestone unit he asked if anyone had checked the resident's medical record for code status. RN A recalled he told the DON he had not yet checked the resident's code status. He explained the DON and RN B stayed in the resident's room while he went to review the chart. He said that shortly after, Emergency Medical Services (EMS) personnel arrived, assessed the resident and cardiac monitor showed no heart activity. RN A explained he was not aware resident #1 received CPR while he was at the nurses' station reviewing the chart. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:20 PM, during a telephone interview, RN D stated she was passing medications on the Pebblestone unit when RN A yelled, Hey, I have a Code here. RN D stated RN A placed resident #1 in a wheelchair and took her to her room. RN D recalled she ran to the DON's office and told him there was a Code Blue on Pebblestone unit. RN D said she informed RN B, the Cliffstone unit nurse, that there was a Code on Pebblestone unit. RN D acknowledged she was supposed to check the medical record for code status, and use the overhead paging system to announce Code Blue. She explained she was very nervous and ran to the DON's office instead. She said she followed RN B and the DON into resident #1's room and when the resident stopped breathing, RN B asked the DON if she needed to initiate CPR. RN D noted she observed RN B perform chest compressions while the DON gave supported respirations using a bag-valve-mask (BVM) device. RN D indicated she left the resident's room at that time and went to the nurses' station to verify resident #1's code status in the medical chart. She said during review of the medical record with RN A, the assigned nurse, and RN C, the oncoming dayshift nurse, they discovered resident #1's yellow DNRO form. She explained the DNRO form should have been at the front of the chart and it wasn't. She reported that when the DNRO was found, they realized the resident was not to be resuscitated. She explained RN C took the chart with the yellow DNRO form to resident #1's room and informed the DON and RN B about the code status. RN D acknowledged the DNRO represented resident #1's wishes. On [DATE] at 1:56 PM, RN C stated she arrived on the Pebblestone unit on the morning of [DATE], and Code Blue was in progress. RN C recalled RN A and RN D were at the nurses' station and EMS was on the telephone. RN C acknowledged after verification of DNR status with RNs A and D, she took the chart to resident #1's room. RN C explained that the resident's code status should be checked first thing and nursing staff should follow this direction. On [DATE] at 2:18 PM, during a telephone interview, RN B confirmed RN D alerted her to a Code Blue on the Pebblestone unit. RN B recalled when she entered resident #1's room, the DON, RN A and D were already at the bedside. RN B recalled the DON asked for the BVM, and she knew a Code Blue meant CPR would be needed. RN B said she asked the DON if she should initiate CPR, to which he responded yes. She said she began performing chest compressions and acknowledged she should not have without verification of code status. RN B stated when she heard RN D yell, Code Blue, she assumed resident #1 was full code, but did not ask. She said she was not familiar with the facility's process as she had not received orientation about advance directives protocols. She acknowledged RN C entered the room with resident #1's chart a few minutes after they initiated CPR and told them the resident had a DNRO. She reported she performed compressions for approximately 2 minutes while the DON handled the BVM. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:52 PM, the DON recalled early in the morning of [DATE] he was in his office when RN D ran in and yelled, Code Blue, Code Blue, Code Blue. He said he asked RN D if the resident was a full code and she answered, Yes. The DON explained he headed towards the resident's room while RN D continued yelling Code Blue as she ran towards RN B who was in the Cliffstone unit. He said when he arrived at the Pebblestone unit nurses' station, he saw RN A with a chart. The DON asked RN A if the resident was a full code and RN A answered, Yes. He explained he acted on verbal confirmation of code status by 2 RNs. He recalled when he arrived at resident #1's bedside, he assessed her and noted a bounding pulse but she was gasping for air. He then asked staff to provide a BVM and directed staff to call 911. The DON stated he shook resident #1 and called her name and she opened her eyes, looked up at him, and her head fell to the left. He said he then told RN B, We need to start CPR. The DON stated they probably performed 2 cycles of CPR before RN C entered room with EMS personnel and informed resident #1 had a DNRO. According to American Heart Association, one cycle of CPR consists of 30 compressions and 2 breaths (Retrieved from www.heart.org on [DATE]). He remembered EMS personnel placed cardiac monitor on resident and pronounced her dead. The DON explained he trusted the RNs and took their word regarding the resident's code status. In hindsight, I knew as a DON I should have checked. He explained the facility process was for nurses to verify code status with the yellow DNRO in the chart, and not the electronic medical record. The DON explained the Code Blue procedure directed staff to use the intercom and page the phrase Code Blue. On [DATE] at 3:52 PM, the Administrator stated he received a call from the DON on [DATE] at 7:08 AM explaining they performed CPR on a resident who had a DNRO. The Administrator noted he conducted an investigation and the Root Cause Analysis showed nurses did not follow the facility's procedures related to verification of code status prior to initiating CPR. He explained the procedure required verification by 2 nurses of the actual yellow DNRO form. On [DATE] at 2:43 PM, the Clinical Quality Specialist explained the facility had not conducted a Code Blue mock drill in the previous 9 months, since [DATE]. She said this factor likely contributed to the incident and acknowledged nursing staff did not honor resident #1's wishes. She explained the facility's policy directed staff to check the medical record and have 2 licensed nurses verify the code status and noted this was not done. She stated her expectation was one staff member would stay with the resident while another one checked the chart. On [DATE] at 9:08 AM, during a telephone interview, resident #'s 1 granddaughter stated she was not aware her grandmother had received CPR until a few days after she died when an anonymous staff member called to inform her of the incident. She explained a DNRO was her grandmother's decision as she often expressed that she had already lived a long life. The granddaughter stated she was saddened, angry and disappointed the facility did not honor her grandmother's wishes. She expressed concerns that other residents' wishes for DNR would not be honored. On [DATE] at 1:00 PM, during a telephone interview, the facility's Medical Director stated she was resident #1's attending physician. She explained resident #1 was admitted to the facility with a DNRO and that every DNRO yellow form must be easily accessible, in the front of the residents' chart. She could not explain why this breakdown in process occurred. She said, Knowing who is DNR at the beginning of their shift would be a good way to start for all nurses. The problem was they reacted before they verified. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the undated job description for the Director of Clinical Services (or DON) revealed he/she would ensure all nursing staff were knowledgeable of the residents' rights including honoring the right to refuse treatment. The Facility Assessment reviewed by the Quality Assurance and Performance Improvement (QAPI) committee on [DATE] revealed every staff member would show competency in resident rights and changes of condition. The facility's policy and procedure titled Advanced Directives revised on [DATE] read, The center will abide by state and federal laws regarding advance directives. The center will honor all properly executed advance directives that have been provided by the resident and/or resident representative. Review of immediate actions to remove the Immediate Jeopardy implemented by the facility revealed the following, which were verified by the survey team: *On [DATE] to [DATE], the Clinical Quality Specialist provided individualized training on determining resident code status to the five licensed nurses involved in the incident. *On [DATE] and [DATE], RNs A and B and the DON were suspended pending investigation. *On [DATE], the Director of Social Services (SSD) conducted a whole house audit of 79 medical records, 100% of all residents. The SSD verified all residents with DNROs had yellow forms placed as the first item in the chart. *On [DATE], ad hoc Quality Assessment Performance Improvement committee meeting was held to conduct a root cause analysis and develop a Performance Improvement Plan. The root cause analysis identified lack of consistent staff training in orientation and failure to conduct ongoing monthly Code Blue mock drills as contributing factors. The meeting was attended by Medical Doctor (via telephone), Executive Director, Clinical Quality Specialist, MDS Coordinator, Case Manager, Unit Manager, Human Resource Coordinator, Business Development Coordinator, Central Supply, Business Office Manager, Maintenance Director, Activities Director, and Director of Rehab Services. *On ,d+[DATE] to [DATE], licensed nurses received education to include CPR Policy & Procedure (P&P), Advanced Directives Policy & Procedure (P&P), Nurse Practice Act, Resident Rights, Following Physician Orders and Abuse/Neglect/Exploitation/Misappropriation. The facility achieved 100% compliance with 17 of 17 licensed nurses including one agency nurse received education. Post tests were used to validate comprehension and all nurses obtained a passing score. In-service attendance sheets were used to validate participation by all facility staff. *On [DATE] to [DATE], the facility conducted five Code Blue mock drills and staff participation validated understanding and competency. Review of Code Blue drill forms revealed signature of responders and a drill critique with opportunities for improvement as indicated. *Newly hired licensed nurses and any agency staff will receive education upon hire or accepting a shift, to include CPR P&P, Advanced Directives P&P, Nurse Practice Act, Resident Rights, Following Physician Orders, Abuse/Neglect/Exploitation/Misappropriation and participation in Code Blue drills. (continued on next page)

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