STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105552	A. Building B. Wing	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandy Ridge Center for Rehabilitation and Healing	5360 Glover Lane Milton, FL 32570

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30584 Based on staff interviews, record review, policy review, and review of the facility corrective action plan, the facility failed to initiate basic life support including Cardio-Pulmonary Resuscitation (CPR) for 1 of 3 residents sampled for Advanced Directives (#1). The facility failed to commence CPR after finding resident #1 in bed without respirations and heartbeat. The facility failure to initiate CPR led to a determination of Immediate Jeopardy at a scope and severity of isolated, (J). The Director of Nursing (DON) and the Nursing Home Administrator were informed of the Immediate Jeopardy on [DATE] at 2:45 PM. The Immediate Jeopardy began on [DATE] at approximately 5:30 AM and was corrected on [DATE] after verification of compliance achievement. The findings include: A review of the facility investigation dated [DATE] found that Licensed Practical Nurse D (LPN D) failed to honor Resident #1's Advanced Directives. On the early morning of [DATE] at approximately at 5:30 AM, Certified Nursing Assistant A (CNA A) entered the room of Resident #1 to get her up for breakfast and found the resident unable to arouse. CNA A immediately informed the nurse, LPN D, who entered the room and found Resident #1 to be without heartbeat or respirations. LPN D then asked a second nurse, LPN C, to verify her findings. LPN D made three attempts to notify the family of the change in condition and post-mortem care was provided. LPN D did not initiate basic life support to include cardiopulmonary resuscitation (CPR) nor did she contact Emergency Medical Services (EMS), the physician, the administrator, or the Director of Nursing (DON). A review of the medical record for Resident #1 found that Resident #1 was admitted in early 2021 and expired at facility on [DATE]. Resident #1 had diagnoses which included cerebral infarction (stroke), type 2 diabetes mellitus (condition involving the way the body regulates and utilizes sugar and insulin), dementia with severe agitation, major depressive disorder, generalized anxiety, dependence of supplemental oxygen and hypertension (high blood pressure). A review of the Advanced Care Planning Discussion/Review form for Resident #1 dated [DATE] found the Resident Physician Ordered Code Status to be Full Code (basic life support including CPR should be initiated in case of death). (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 2:22 PM, an interview was conducted with Registered Nurse B (RN B), who stated she arrived at facility at approximately 7:10 AM on [DATE]. Upon arrival, the person at the front desk (CNA F) made her aware that Resident #1 had died . RN B found LPN D and inquired about Resident #1. LPN D informed her that Resident #1 had died . RN B stated she asked LPN D if she performed CPR, and LPN D replied, no. RN B stated that LPN D denied calling EMS, the DON or the Administrator. RN B stated when she asked LPN D if she was aware that Resident #1 was a full code, LPN D replied, I did not check. RN B stated that upon assessment she found Resident #1 pale, cold, stiff, mouth open, and eyes closed. RN B stated she called 911 per facility protocol for an unresponsive resident with a full cardiovascular code status. On [DATE] at approximately 2:44 PM, an interview was conducted with CNA A who stated she was rounding (going room to room) with CNA E, and they entered Resident #1's room together and found Resident #1 laying on her back holding her doll that her husband had brought her. Her face looked a little greyish and she was unresponsive, cold, and not breathing. CNA A reported that she instructed CNA E to go get the nurse while she (CNA A) remained at bedside. CNA E immediately returned to the room with LPN D who checked for pulses and stated the resident had no pulses and that the resident was dead. CNA A further stated 911 was not called and there were no cardiovascular compressions provided to Resident #1. CNA A stated she and CNA E cleaned Resident #1 to get her ready for her husband. She looked like she was at peace. On [DATE] at approximately 10:51 AM, an interview was conducted with LPN D who stated that she is sad and she feels for the family. She stated that she wanted to apologize and was not aware Resident #1 was a full code. LPN D stated that CNA E came to get her around 5:25 AM to 5:30 AM, and informed her Resident #1 was unresponsive. LPN D stated she checked her pulses and listened with the stethoscope, and she was gone. LPN D stated she had last seen Resident #1 at about 4:13 AM when she checked the resident's oxygen saturation. On [DATE] at approximately 3:03 PM, an interview was conducted with LPN C who stated that she was at the nurse's station getting ready to pass morning medications when CNA A stepped out of Resident #1's room and stated that Resident #1 was gone. LPN C stated that LPN D borrowed her stethoscope, checked the resident and then returned to the nurses' station and asked her to also check Resident #1. LPN C stated she checked Resident #1 and found no heartbeat. Resident #1 was still warm, but her fingers were a little blue. She looked peaceful. During a clarification interview on [DATE] at approximately 11:31 AM, LPN C stated she checked Resident #1 around 5:45 AM. LPN C stated she checked the resident's wrists and neck and found no pulses, then put a stethoscope on her chest, but could not hear respirations or a heartbeat. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 11:00 AM, an interview was conducted with the DON, Risk Manager and Administrator about the incident, facility response and facility policies. The DON stated LPN D indicated that she assumed the resident had a DNR (do not resuscitate) order because she recalled previously seeing a goldenrod paper in her chart. Upon investigation, there were no goldenrod colored papers in the resident's record, but the chart did contain a dark gold colored section divider. These have since been removed. The resident's husband visits daily, and had not reported any condition changes the evening before. Staff had seen Resident #1 around 4:30 AM with no changes in condition. At approximatley 5:30 AM, 2 CNAs tried to arouse her and immediately called out for the nurse because she wasn't responding. The Administrator and DON immediately drove to the facility. The staff reported that the first thing they did was to obtain witness statements and initiate a PIP (performance improvement plan). They suspended both nurses and LPN D will be terminated and reported to the Florida licensure board. Abuse Registry and law enforcement (LE) were both notified and LE came on site. The team reported that after they started looking at every resident's code status to ensure it was correct and a corresponding goldenrod DNR paper was included in the file as indicated. They reported auditing all nurses' training records for CPR status and found that everyone was certified. The team then started conducting Mock Cold Blue drills every shift beginning on [DATE] with plans to continue until 100% staff are all retrained. The team reported that the facility does not allow CNAs to perform CPR, but there is always a nurse nearby who can start immediately. The staff that night included 2 nurses and 4 CNAs. The team reported that LPN D was devastated about what happened. The facility policy is to start CPR until the resident's status is verified. All staff have all been educated to go and grab that CPR/DNR book immediately and we are drilling in on the importance of verifying and double checking the residents code status. The Social Services Director is responsible for updating the code status of each resident, and coordinating the DNRs with the physicians. Review of facility policy Nursing-Emergency Care (CPR), undated, was conducted. The policy instructed: In the event of a medical emergency, the facility will notify the attending physician and/or call 911 according to the resident's advance directives. The policy further stated: In the absence of a Do-Not-Resuscitate (DNR) order or for those residents who do not have a valid DNR order, CPR must begin. Review of facility's Licensed Practical Nurse (LPN) position description was conducted. The LPN's essential functions included to initiate emergency support measures (i.e. CPR). The facility provided a corrective action plan to the survey team upon entrance on [DATE]. The facility's corrective measures included the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A review of the facility's investigation and interview with the Administrator and DON found that the Administrator, DON, and Risk Manager (RM) began investigation immediately on [DATE] at approximately 7:20 AM upon notification of LPN D's failure to honor Resident #1 advanced directive (full code status) and resident death. The investigation began with interviews with staff on duty at the time of the event and review of the residents' medical record. The nurse assigned to the resident was LPN D had been an employee since [DATE]. LPN C, who was called to the room about ,d+[DATE] minutes after the event, was hired [DATE]. The Administrator and DON verified that both LPN D and LPN C completed annual training including education and training on residents' rights related to honoring advanced directives, emergency care (CPR) and verified CPR certification is active and up to date. LPN D was terminated from employment on [DATE]. Appropriate referrals were made to the department of health, abuse hotline, EMS, and police. A QAPI sub-committee consisting of the DON, Administrator, RM and Medical Director discussed the investigation and audit findings on [DATE] and made plans for further steps, such as the initiation of Mock Codes (training drills for emergency response). The investigation findings were again discussed during a full Ad-hoc QAPI team meeting on [DATE]. The survey team verified this via review of the investigation, audit findings, QAPI minutes and interviews with the Administrator, DON and RM. -Upon completion of a root cause analysis, it was identified that the process required to effectively train and communicate the facility's Emergency Care/CPR and Abuse/Neglect/Exploitation policies were in place. The root cause analysis identified one Licensed Practical Nurse (LPN D) failed to validate the code status of her resident leading to CPR not being implemented. LPN D who failed to initiate CPR on the resident was verified to have a current and active license to practice and current CPR certification. This nurse had been educated and trained in the facility's emergency care/CPR policy and chose not to comply. This nurse stated she thought this resident was a DNR and failed to verify code status, so she did not initiate CPR. The survey team verified this via review of the investigation and policies and staff interview. -The DON and Risk Manager initiated re-education on [DATE] at 4:30 PM with licensed nursing staff including LPN D & LPN C (just before suspension) on honoring advanced directives, location of advanced directives, and facility process for ensuring CPR is provided to residents with full code status. All nurses not out of town, 15 of 20 nurses on staff, completed this education by [DATE]. All nurses will be required to complete the training prior to their first shift. The survey team verified this via training record review and interviewing 7 nursing staff representing all 3 shifts. -Mock code-blue drills (CPR response) were initiated [DATE] at 6:00 PM and were every shift. There were 7 Mock Code Drills completed prior to the survey team's entrance which included 13 of 20 nurses on staff (out of town nurses, plus the 2 suspended nurses, LPN C and D had not partipated in a mock code). All nurses will be required to participate in a mock code their first shift back. An after-action evaluation was completed following each mock code drill. The facility has plans to continue mock code drills until quality goals are met. The survey team verified this via training record review, DON interview, QAPI review and interviewing 7 nursing staff representing all 3 shifts. -Audits were conducted immediately on [DATE] by the DON for all residents under the care of LPN D to ensure no identifiable changes in conditions were present. No concerns were identified. The survey team verified this via audit review and DON interview. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An audit was completed immediately on [DATE] by the DON and Administrator to ensure all current residents advanced directives were documented and code status was is in place and current. All 56 residents had current code status verified in place and accurate for both the paper and electronic medical records. The survey team verified this via clinical record review, audit review and interview with the DON and Administrator. -An audit was completed by Human Resources (HR) of all licensed nursing staff to ensure CPR certification was in place and current. 100% of licensed nursing staff had current CPR certification in place. HR also verified current nursing licensure and background screening requirements with 100% compliance. The survey team verified this via personnel record review, and interview with the DON, Administrator and HR Director. -Nurse competencies, which include emergency response and CPR were audited to ensure current. All nurses employed as of [DATE] were current with their skills competencies. The survey team verified this via personnel record review, audit review and interview with the DON. -Performance improvement plan (PIP) including immediate plan of action reviewed and approved during AD HOC QAPI meeting held [DATE] at approximately 2:00 PM with the Interdisciplinary Team and the Medical Director. Attendees included the Administrator, DON, Minimum Data Set Coordinator, Medical Director, Risk Manager, Restorative Nurse, Social Services director, Housekeeping and Maintenance Directors, Admissions Director, Medical Records Coordinator, Nursing Supervisor, Therapy Director, Dietary Supervisor, Business Office Manager and Staffing Coordinator. The survey team verified this review of QAPI plan and minutes and interview with the DON, RM and Administrator. -The morning of [DATE] at about 9:00AM, the Administrator, DON and department heads again reviewed the current PIP, mock code drills, education, and implementation of the new Code Status binder for all residents. The team discussed the after action reports from the mock code drills conducted the day before. The survey team verified this via interview with 7 nursing staff, interview with the DON and administrator and review of the QAPI plan and minutes. -A review of the PIP found a new process to identify residents who are a full code status. Previously, residents who elected DNR [do not resuscitate] status had a goldenrod colored form in the front of their paper charts. The new process was to include a bright pink sheet in the front of the resident paper charts to identify resident's with full code status. Additionally, the facility augmented the current system by including a separate Code Status binder at the (only) nurses' station for quick and easy reference. All staff who were not out of town had educated on this new process by [DATE]. All remaining staff will receive education prior to their next shift. The Social Services Director, Administrator, Nurse Supervisor on duty or designee will be responsible to update the resident chart and Code book as changes are received. The survey team verified this via interview with about 7 nursing staff, interview with the DON and review of the binders. -Facility Crash carts were audited to ensure all necessary items/supplies were present and in date. The survey team verified this via interview with the DON and observation of the crash carts. (continued on next page)

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