

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/10/2021
NAME OF PROVIDER OR SUPPLIER Aspire at Kissimmee Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Findings:</p> <p>Resident #1 was a [AGE] year-old, admitted to the facility on [DATE] with diagnoses of congestive heart failure and osteoarthritis.</p> <p>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.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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