| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335706 | A. BUILDING _____ B. WING _____ | 03/04/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| IRA DAVENPORT MEMORIAL HOSPITAL S N F/ H R F | 7571 STATE ROUTE 54 BATH, NY 14810 |

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) |
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| F 0678<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, and record reviews conducted during the Abbreviated Survey (complaint #NY 358), it was determined that for 1 (Resident #1) of 1 resident reviewed for Cardiopulmonary Resuscitation (CPR), the facility did not ensure that the resident received CPR in accordance with the resident's wishes, and for 11 (Residents #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12) of 104 residents reviewed for advanced directives, the facility did not ensure the residents' advanced directive wishes were consistently documented correctly. This is evidenced by, but not limited to, the following: 1. Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated [DATE], revealed that the resident had moderately impaired cognition. Review of the facility policy, CPR, dated as revised [DATE], revealed that in the event of circulatory and/or [MEDICAL CONDITION] of a resident CPR will be performed unless the resident has a Do Not Resuscitate (DNR) order. All residents who wish to be a full code (CPR) will have a blue dot posted on the face sheet, nameplate outside the resident's room, on the outside of the resident's chart, and on the resident's name band. The policy includes that all staff will be offered CPR annually, and all supervisors and charge nurses will be required to be current with their CPR certification. Review of the facility policy, Advanced Directives, dated as reviewed on February 2012, revealed that all residents have the right to execute the advanced directives concerning life sustaining treatment. The policy includes that the Social Work Department will document the Advanced Directives in the front of the resident's medical record. The policy did not include any other areas where a resident's advanced directive wishes were documented. The current physician orders, Comprehensive Care Plan, and the Resident Mini Door Care Plan (posted in all residents' closets) revealed that the resident wished for CPR in the event of circulatory or [MEDICAL CONDITION]. The facility investigation summary, dated [DATE] and signed by the Director of Nursing (DON), revealed that the resident was found on [DATE] at 7:05 a.m. by two Certified Nursing Assistants (CNAs) lying in bed and not looking right. The CNAs called for Licensed Practical Nurse (LPN) #1 who responded and found the resident cold to touch. LPN #1 was unable to get any vital signs. LPN #1 then called the Registered Nurse (RN) Supervisor from the attached hospital who was covering as a supervisor for the facility. LPN #1 did not start CPR. LPN #1 then checked the resident's chart which documented the resident was a full code (wishes for CPR). LPN #1 called the RN Supervisor back who then arrived and declared the resident deceased . The RN Supervisor stated they would not initiate CPR as the resident was cold and vital signs were absent. The summary included that the staff present, in their panic, did not note the resident's code status until after reviewing the resident's chart. The CPR policy was reviewed with LPN #1 and the RN Supervisor regarding initiation of CPR per the resident's wishes until medical arrives. Interviews conducted on [DATE] included the following: a. At 10:12 a.m., LPN #1 stated she was told by two CNAs that the resident was not breathing. LPN #1 said she then went into the resident's room and found the resident was not breathing, had no pulse, and was cold. LPN #1 said she left the room and called the covering RN Supervisor from the hospital. LPN #1 stated that she then checked the resident's chart and found that the resident was a full code, so she called the RN Supervisor back. She said the RN Supervisor immediately responded and pronounced the resident dead. LPN #1 said she knew that she was not allowed to pronounce a resident's death but did not know she was supposed to initiate CPR until the RN or medical arrived and pronounced the resident dead. She said when she called the RN Supervisor back and reported that the resident was a full code, the RN Supervisor did not tell her to begin CPR. b. At 12:28 p.m., the RN Supervisor stated that when LPN #1 first called her she told her she thought the resident was a DNR. She said LPN #1 then called her back and told her the resident was a full code. The RN Supervisor said she did tell LPN #1 to start CPR. She said she did not know that she should have told LPN #1 to start CPR. c. At 8:50 a.m., 9:32 a.m., and again at 1:55 p.m., the DON stated that according to the facility policy, a blue dot means full code (CPR) and a black dot means DNR. She said the dots are posted for every resident on the resident's chart binder, nameplate on their doors, on the Mini Door Care Plans in each resident's closet, and on a wristband if worn (though many residents do not wish to wear one). The DON said that all staff are trained in CPR, and they should all know that they are supposed to start CPR until medical or an RN pronounces a resident deceased . The DON said that an LPN cannot pronounce a death. She said LPN #1 should have initiated CPR but she panicked and did not. She said both CNAs should have initiated CPR, but they did not either. 2. On [DATE] at 9:30 a.m., observations conducted on three of three residential units revealed that every resident door had a black dot or a blue dot on the resident nameplate to identify their code status. The dots did not match the code status information on the nursing report sheet that was provided by the facility to the surveyor as evidenced by, but not limited to the following: a. A Unit: Resident #2 had a black dot on their nameplate which means DNR, but the report sheet documented the resident was a full code (CPR status). b. B Unit: Resident #7 had a black dot on their nameplate which means DNR, but both the report sheet and the mini door care plan documented the resident was a full code. c. C Unit: Resident #12 had a black dot on their nameplate which means DNR. The mini door care plan in the resident's closet documented the resident was a full code (CPR status). Interviews conducted on [DATE] included the following: a. At 11:40 a.m., LPN #2 stated that a resident's code status was located on the chart spine, resident's wristbands, nursing report sheets and mini door care plans. LPN #2 said she would check the door first then the mini door care plan to determine if she needed to start CPR. b. At 11:50 a.m., LPN #3 stated she would check the resident's chart to determine a resident's code status. She said if the chart was unavailable, she would then check the nursing report sheet. c. At 1:55 p.m., the DON said she asked the unit clerks to ensure all residents' code status was correct in all areas used but it does not appear that it was done. The DON said that when a resident's code status changes, the unit clerks are supposed to update it everywhere. She said the resident's code status was listed in too many places to keep accurate and needs to be changed. The DON said she was in the process of revising the facility policy and conducting mandatory in-services for all employees. (10 NYCRR 415.3(e)(2)(iii)) |

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