STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREST MANOR LIVING AND REHABILITATION CENTER	6745 PITTSFORD PALMYRA ROAD FAIRPORT, NY 14450

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** - Minimal harm or potential for actual harm **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** Based on interviews and record reviews conducted on [DATE] during the COVID-19 Focused Infection Control Survey and a complaint investigation (#NY 624), it was determined that the facility did not have an organized, effective system in place to ensure resident wishes regarding Cardiopulmonary Resuscitation (CPR) were implemented for one of five residents reviewed. Specifically, Resident #1 (code status Do Not Resuscitate-DNR) was found unresponsive, and CPR was initiated. This is evidenced by the following: Review of the facility policy, Advanced Directives, dated [DATE], revealed that upon admission the resident was asked about their goals of care. If a Medical Orders for Life Sustaining Treatment (MOLST) form was not completed, they are asked to complete one. Upon completion of the MOLST form, orders will be written to reflect choices made and the MOLST will be filed in the resident's chart. The undated facility policy, CPR, Automated External Defibrillator, Code Green, included that residents who are full code will wear an identification band with a green dot on it, and there will be a green dot on the name label of their chart. A resident's DNR request will be respected when a valid order exists unless the information is not readily available to on-scene staff at the time of the arrest. Resident #1 was diagnosed with [REDACTED]. On [DATE], the Social Worker completed a Brief Interview for Mental Status and documented that the resident was cognitively intact. The Medical Orders for Life Sustaining Treatment (MOLST), signed by the resident on [DATE], documented the resident was a DNR. The Physician's orders. dated [DATE], documented the resident was a DNR. The Face Sheet and Baseline Care Plan, both dated [DATE], included that the resident was a DNR. The Nurse Progress note, dated [DATE] at 7:50 p.m. (late entry from Registered Nurse (RN) Supervisor), documented that she was advised by the Licensed Practical Nurse (LPN) that she had gone into the resident's room to give him meds, and she thought the resident was gone. I asked her if she knew the code status, and she stated she did not know. I am not sure I went to the chart rack, where the pink MOLST forms are, and the resident's MOLST form was not filled out. CPR was started and 911was called. Once EMS arrived, I was able to review notes and admission notes and it was documented DNR, DNI (do not intubate), DNH (do not hospitalize), comfort measures only. CPR was stopped and the resident was pronounced. During a telephone interview on [DATE] at 1:00 p.m., the Director of Nursing (DON) stated on [DATE] the resident was found unresponsive, with no pulse, and not breathing. The RN Supervisor checked the paper medical record and could not find a MOLST, so she called a code (emergency when someone is not breathing or has no pulse), called 911, and began CPR. The DON stated Emergency Medical Services (EMS) arrived within five to ten minutes and CPR was stopped by EMS. During a telephone interview on [DATE] at 10:31 a.m., the RN Supervisor stated she was on the unit on [DATE] when the LPN came to the resident's doorway and said she thought the resident had expired. The RN Supervisor said she observed the resident to be nonresponsive, not breathing, and pulseless and asked the LPN about the resident's code status. She said the LPN responded she did not know the resident's code status. The RN Supervisor said she went to the paper chart and found a blank MOLST and told the LPN to call a code and start CPR. She said that the resident did not have an identification band on which would have revealed their code status. The RN Supervisor said she was always taught that if the code status was unknown, CPR should be initiated. She said the resident should have had an identification band on with the code status and the MOLST should have been completed and in the medical record. She said that the facility has used an electronic medical record system for four months. She said she was not taught, until after the incident, that the resident's code status would appear on the computer as soon as the resident's name was brought up on the screen. During a telephone interview on [DATE] at 10:52 a.m., the LPN stated she was aware that the resident had a hospice referral but was not aware of the resident's code status. She said that on [DATE] during the evening shift the resident was not feeling well but was alert and responsive. The LPN said late that evening she found the resident unresponsive. She said the RN Supervisor was right in the hallway, so she asked her to come in and see the resident. The LPN said the RN Supervisor asked her about the resident's code status but she did not know the resident's code status. The LPN stated the resident was not wearing an identification band. She said the RN Supervisor went to check the medical record for a MOLST and came back and said it was blank. The LPN stated the RN instructed her to start CPR, call a code, and call 911. The LPN said that when EMS arrived, they told her to stop the CPR and the resident was pronounced deceased . The LPN said she had been using the electronic medical record system since [DATE] and was not aware that the resident's code status or the MOLST was on the computer. The LPN said she knew the code status was documented on the electronic medication administration record. She said the identification band should have been placed on the resident by whoever completed the MOLST. During a telephone interview on [DATE] at 10:37 a.m., the RN Manager said that she did not complete the resident's admission and was not aware the resident was not provided with an identification band with their code status. She said the identification band should have been provided by the Front Desk Receptionist, and the floor nurse then puts the identification band on the resident. She said that she was not aware that the MOLST form was not in the medical record. She said the MOLST form could have been in the Nurse Practitioner binder awaiting a signature. During a telephone interview on [DATE] at 11:00 a.m., the staff RN said she remembers completing the MOLST and admission paperwork on the resident. She said the identification bands do not usually arrive on the unit until the evening shift or the next day. She said when the MOLST was completed on [DATE], it was signed by the Physician's Assistant (PA) and put in the front of the paper chart. She said she does not know why the RN Supervisor would have found a blank MOLST in the chart. The staff RN stated she remembered that the PA entered the orders, including DNR into the electronic medical record because she took off the orders. She said the DNR code status populated into the face sheet, next to the resident's photograph, and on the medication administration record. (10 NYCRR 415.3(e)(1)(ii))

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