STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335865	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAMARITAN SENIOR VILLAGE, INC	22691 CAMPUS DRIVE WATERTOWN, NY 13601

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** - Minimal harm or potential for actual harm **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** Based on observation, record review and interview during the abbreviated survey (NY 250), the facility did not ensure a resident's right to request, refuse, and/or discontinue treatment, and to formulate an advance directive for 2 of 4 residents (Residents #1 and 2) reviewed for advance directives. Specifically, Resident #1 opted for a Do Not Resuscitate (DNR, allow natural death, do not perform cardiopulmonary resuscitation, CPR, in the event the heart stopped) order and when the resident was found unresponsive, facility staff performed CPR (chest compressions) on the resident. Resident #2 changed their advance directives from a full code (CPR) to DNR, and the resident continued to wear a green bracelet indicating their wishes were for CPR in the event their heart stopped. Findings include: The ,[DATE] revised Green Code and Basic Life Support policy documents the following: - Basic life support will be performed on a resident found unconscious; not breathing normally or showing no signs of circulation if they had a Full Code status. - A list of residents who wished to be resuscitated (Green Code list) will be located at the nursing station on each unit. Staff were to refer to the Green Code list or chart orders for confirmation of code status. Residents who request resuscitation will be encouraged to wear a green bracelet. - The first person on the scene who is CPR (cardiopulmonary resuscitation, chest compressions) certified will initiate CPR until other staff arrive. The person discovering the unresponsive resident is to call Green Code and location and repeat until assistance arrives or at least three times. 1) Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The [DATE] Minimum Data Set (MDS) assessment documented the resident was cognitively intact and did not have a Do Not Resuscitate (DNR, allow natural death) or Do Not Intubate (DNI, no breathing tube) order. The [DATE] physician's orders [REDACTED]. The comprehensive care plan (CCP), updated [DATE], documented the resident wanted to be resuscitated and wanted every effort to sustain life. The [DATE] Medical Orders for Life-Sustaining Treatments (MOLST) documented the resident's wishes were for CPR, trial intubation, and limited medical interventions. The form was signed by the resident. When reviewed at the time of the investigation, the form had Void written across the first page; the signature page documented on [DATE], the form was voided by nurse practitioner (NP) #9, and a new MOLST was completed. The [DATE] MOLST documented the resident's wishes were for a DNR and DNI order. The MOLST was signed by the resident and physician's assistant (PA) #10 and was cosigned by the Medical Director. The [DATE] certified nurse aide (CNA) Care Card (care instructions) documented the resident was a DNR. The Green Code List, dated [DATE], documented the resident wanted CPR. The [DATE] nursing progress notes documented: - At 7:00 PM, licensed practical nurse (LPN) #1 documented, at 6:50 PM, CNA #7 called out from the resident's room and said she did not like how the resident's coloring looked. LPN #1 entered the room, the resident was pale and losing consciousness. LPN #1 called registered nurse Supervisor (RNS) #2. - RNS #2 documented she was called to the resident's room at 6:55 PM. The resident was unresponsive, and CPR was in progress when she arrived. The resident had agonal breathing (struggling, having difficulty breathing) with no audible or palpable pulse. At approximately 7:10 PM, LPN #5 notified RNS #2 that the resident was a DNR/DNI and CPR was stopped. The resident was pronounced deceased at 7:12 PM. - Registered Nurse (RN) #3's progress note documented at 7:10 PM, she arrived to the resident's room and the resident had agonal respirations. RN #3 listened for an apical pulse and found none, the resident's pupils were fixed and dilated, and the resident was pronounced deceased at 7:12 PM. - LPN #4 documented she received a Code Green notification over her Vocera (a communication device) and she went to the room with LPN #5. LPN #5 initiated oxygen and an ambu bag (assists with ventilation) and LPN #4 took over chest compressions for RNS #2. Chest compressions and ventilation was continued by RNS #2, and LPNs #4, #5 and #8 until another nurse yelled out that the resident was a DNR. Chest compressions and the ambu bag were ceased at that time. - LPN #5 documented a code was called by LPN #1 over the Vocera. When LPN #5 entered the room, CNA #7 was doing chest compressions. LPNs #5, #3, #8 and RNS #2 provided chest compressions and ventilation to the resident. LPN #5 then noted the resident was a DNR and announced the resident's code status to the staff doing CPR. Chest compressions were stopped. During an interview on [DATE] at 2:09 PM, CNA #7 stated residents who were a full code wore a green bracelet, but she did not think Resident #1 had a green bracelet on and thought the resident was a full code from the Green Code list. CNA #7 stated on [DATE], the resident became sweaty, shaky, and pale and then unresponsive so she called for the nurse and began chest compressions. She stated she found out later that the resident had a recent change in her code status and the resident was no longer supposed to be on the Green Code list. During an interview on [DATE] at 12:21 PM, LPN #4 stated she would check a resident's code status on the MOLST as that was the most reliable method to identify code status. LPN #4 stated there was also a Green Code list hanging by the nurse's station and residents had an order for [REDACTED].#4 stated the night the resident coded, she and LPN #5 were in the medication room when she received a Vocera call from LPN #1 for a Code Green. When she and LPN #5 got to the room, the crash cart was there so she ran to get oxygen and the ambu bag and took over compressions for RNS #2. She stated herself and LPNs #5 and #8 continued to rotate through chest compressions until an unknown staff member yelled out to stop CPR as the resident was a DNR. She stated the initial LPN on the scene was responsible for checking a resident's code status before starting a code. She was told that the resident had a recent change in code status that had not been updated on the Green Code list. During an interview on [DATE] at 2:42 PM, LPN #5 stated code status was found in the paper chart, on the CNA care card, residents who were full code wore a green bracelet, and there was an order in the electronic medical record if it was updated. She stated the Green Code list hanging on the unit was supposed to be the most up to date documentation of code status and the LPN was responsible for checking it against the MOLST. The night of the resident's code, LPN #5 was in the medication room when she received a call over her Vocera from LPN #1 stating there was a code green. She found CNA #7 and LPN #1 in Resident #1's room with the crash cart and CNA #7 was performing chest compressions. She took over compressions from CNA #7. LPN #5, LPN #4, and RNS #2 ran through a few cycles of compressions until someone yelled out that the resident was a DNR and chest compressions were stopped. LPN #5 looked at the CNA care card in the resident's closet which documented the resident was a DNR; she stated the CNA who found the resident would have access to this. She stated the charge nurse initiating the code should confirm code status prior to starting the code, and the MOLST should be checked against the sheet. During an interview on [DATE] 9:27 AM, NP #9 stated the providers did not enter orders into the electronic record; they documented on the physician order [REDACTED]. The resident had been assigned to her since ,[DATE]. She stated, she voided the old MOLST because the new MOLST had been completed with PA #10. During an interview on [DATE] at 9:45 AM, LPN #1 stated the night the resident coded, CNA #7 called for her. LPN #1 ran to get the crash cart and checked her cheat sheet which documented the resident was a full code. CNA #7 was doing compressions while LPN #1 got the crash cart. When RNS #2 arrived, LPN #1 went to get the resident's chart and saw the MOLST which documented the resident was a

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) DNR. During an interview on [DATE] at 11:08 AM, PA #10 stated she assisted with updating residents' MOLSTs at the end of March and beginning of [DATE]. After completing the MOLST, she placed the MOLST on top of the resident's chart and gave the chart and MOLST to the RN Manager. During an interview on [DATE] at 11:13 AM, RN Manager #11 stated that if a resident had a change in code status, she would update the CNA care card, the electronic medical record, and the resident's code bracelet if they wore one. RN Manager #11 stated there was also a Green Code list which was completed by an administrative assistant and posted at the nurse's station. She was not aware that the resident's electronic record and physician orders [REDACTED]. During an interview on [DATE] at 9:27 AM, RNS #2 stated when she arrived to Resident #1's room, the code was in progress. RNS #2 stepped in for a fatigued LPN already providing chest compressions. RNS #2 called RNS #3 to the resident's room. When RNS #3 arrived, she checked the MOLST in the chart and LPN #5 checked the CNA care card in the closet. The resident was determined to be a DNR, and compressions were stopped. She stated ideally code status should be determined prior to starting compressions. 2) Resident #2 was admitted to the facility and had [DIAGNOSES REDACTED]. The [DATE] Minimum Data Set (MDS) assessment documented the resident's cognition was intact, she required extensive assistance with activities of daily living (ADLs) and she was a DNR (do not resuscitate). The [DATE] physician's orders [REDACTED]. The [DATE] physician's orders [REDACTED]. The [DATE] Medical Orders for Life Sustaining Treatment (MOLST), signed by the resident, documented the resident wanted a DNR order. The [DATE] at 11:21 AM, social services progress note documented the resident recently updated her MOLST and wanted a DNR order. The [DATE] comprehensive care plan (CCP) documented the resident did not wish to be resuscitated. On [DATE] at 11:38 PM, Resident #2 was observed in bed and wearing a green bracelet on their wrist. The certified nurse aide (CNA) care card (care instructions) in the bedroom closet documented the resident was a DNR. On [DATE] at 12:59 PM, CNA #15 stated in an interview, if she found a resident unconscious, not breathing and wearing a green bracelet, she would start CPR. She stated in addition to the bracelet, she could also check the green code list at the nurse/s station and the CNA care card in the bedroom closet. On [DATE] at 1:30 PM, licensed practical nurse (LPN) #12 stated in an interview, she knew all the residents' code status on the unit, and she checked the Green Code list daily for changes. She stated Resident #2 was a full code, she wore a green bracelet and the resident's name was on the Green Code list. During the interview, she checked the Green Code list and stated the resident's name was not there. She then looked at the resident's MOLST and stated the resident was changed to a DNR. LPN #12 walked to Resident #2s room, looked at the resident's green bracelet and said the bracelet identified a Full Code, and it was not the correct code status. She stated registered nurse (RN) Manager #13 signed as a witness on the MOLST and she would have been responsible to remove the resident's bracelet. On [DATE] at 1:45 PM RN Manager #13 stated in an interview, nursing staff were trained to review the Green Code list at the nurse's station and if a resident wore a green bracelet and was not breathing, nursing staff would initiate CPR. When a resident changed their code status, a new order was obtained and whoever transcribed the order was responsible to remove the resident's bracelet. She stated she was not the nurse that transcribed the resident's DNR order on [DATE] and the nurse that did so should have removed the resident's green bracelet. On [DATE] at 1:53 PM, the Director of Nursing (DON) stated in an interview, she expected nursing staff to know a resident's code status by checking the MOLST, the Green Code list, the CNA care card, and to look to see if they wore a bracelet. If the resident was in their room, the CNA care card should be checked to determine code status. If the resident was not in their room and they had a green bracelet on, she expected CPR to be initiated. Staff should call for help and have someone double check the code status. She stated a full house audit was recently completed, issues were identified, and were corrected. She stated she was not aware Resident #2 continued to wear a green bracelet and it should have been removed when the resident opted for DNR. 10NYCRR 415.3(e)(1)(ii)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during an abbreviated survey (NY 250), the facility did not ensure all alleged violations involving abuse/neglect were reported to the New York State Department of Health (NYSDOH) as required for 1 of 4 residents (Resident #1) reviewed for advance directives. Specifically, Resident #1 had a Do Not Resuscitate (DNR, allow natural death in the event the heart stopped) order and received CPR (cardiopulmonary resuscitation, chest compressions) and the event was not reported to the NYSDOH as required. Findings include: The ,[DATE] NYSDOH Nursing Home Incident Reporting Manual documents the following as a reportable incident, CPR was provided against a resident's wishes and CPR was initiated and stopped when staff became aware of the resident wishes. The facility's policy Accident and Incident, Investigation and Reporting revised ,[DATE] documents any alleged violation of abuse, mistreatment, neglect, injuries of unknown origin, or misappropriation of resident's property will be reported to the NYSDOH if and when the reasonable cause threshold has been achieved. Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The [DATE] Minimum Data Set (MDS) assessment documented the resident was cognitively intact, required extensive assistance for most activities of daily living (ADLs). The [DATE] Medical Orders for Life Sustaining Treatment (MOLST) documented instructions including Do Not Resuscitate (DNR) and Do Not Intubate (DNI). The MOLST was signed by the resident and physician's assistant (PA) #10 and was cosigned by the Medical Director. The [DATE] certified nurse aide (CNA) Care Card (care instructions) documented the resident was a DNR. The [DATE] nursing progress notes documented the following: - Registered nurse Supervisor (RNS) #2 was called to the resident's room at 6:55 PM as the resident was unresponsive. CPR was in progress when she arrived to the room. At approximately 7:10 PM, licensed practical nurse (LPN) #5 notified RNS #2 that the resident was a DNR/DNI, CPR was stopped, and the resident was pronounced dead at 7:12 PM. - LPN #4 documented she received a Code Green notification over her Vocera (a communication device). LPN #5 initiated the oxygen and ambu bag (assists with ventilation) on the resident and LPN #4 took over chest compressions for RNS #2 and chest compressions and ventilation were continued by RNS #2, and LPNs #4, #5 and #8. Another nurse yelled out the resident was a DNR and chest compressions and the ambu bag were ceased. - LPN #5 documented a code was called by LPN #1 over the Vocera. When LPN #5 entered the room; the crash cart was already in the room and CNA #7 was doing chest compressions. LPNs #5, #3, #8 and RNS #2 provided chest compressions and ventilation to the resident. LPN #5 then noted the resident was a DNR and announced to the other nursing staff the code status per the MOLST. Chest compressions were stopped. During an interview on [DATE] at 12:21 PM, LPN #4 stated she and LPNs #5 and #8 continued to rotate through compressions until an unknown staff member yelled out to stop CPR as the resident was a DNR. During an interview on [DATE] at 2:42 PM, LPN #5 stated she responded to a Code Green for Resident #1 on [DATE]. She found CNA #7 and LPN #1 in Resident #1's room with the crash cart and CNA #7 was performing chest compressions. She, LPN #4, and the RNS ran through a few cycles of compressions until someone came and yelled the resident was a DNR. Compressions were stopped. During an interview on [DATE] at 9:45 AM, LPN #1 stated on [DATE] CNA #7 called for her and she ran to get the crash cart and checked her cheat sheet on codes which documented the resident was a full code. CNA #7 was doing compressions. When RNS #2 had arrived and the other LPNs were there, LPN #1 went to get the resident's chart then saw the MOLST which documented the resident was a DNR. The LPN said she did not provide a written statement regarding the event. The Director of Nursing (DON) was interviewed on [DATE] at 1:55 PM, and stated at the time the incident occurred, she did not realize that it was reportable to NYSDOH when CPR was done on a resident against their wishes. She stated when the complaint came in, she realized it should have been reported. The Administrator was interviewed on [DATE] at 2:10 PM and stated the DON did not report the incident to the NYSDOH and did not realize she should check the incident reporting manual when incidents occurred to determine if something was reportable. The Administrator stated she reviewed all incidents but had not received a report on this incident yet. She heard of the incident during morning report and the plan for preventing reoccurrence but did not check to see if it was reported. 10NYCRR415.4 (b) (1) (ii)