STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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 record review, staff and physician interviews the facility failed to clearly communicate code status to a receiving provider and failed to have advanced directives in the physical chart for 2 of 3 residents reviewed for advanced directives (Resident #4 and #17). The findings include: 1. Resident #4 was admitted on [DATE] and readmitted on [DATE] for aftercare following joint replacement surgery. The quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #4 was moderately cognitively impaired. Review of the care plan revealed a care plan focus initiated on 01/24/19 that stated Resident #4 had an advance directive of full code status. On 04/10/19 this care plan was noted to be resolved. On 04/10/19 a care plan focus was initiated indicating Resident #4 had an advance directive of do not resuscitate (DNR). Interventions included: obtain advance directive with physician order [REDACTED]. The goal of the care plan was to honor the patient's wishes. Review of the physical chart for Resident #4 revealed a Medical Order Standard of Treatment (MOST) form signed by the resident guardian with an effective date of 03/05/19 indicating Resident #4 was a DNR with medical interventions to include comfort measures only. The physician orders [REDACTED].#4 had a DNR advance directive. The profile tab, face sheet-which includes information such as emergency contacts, social security number, insurance numbers, admission type, code status, voter status, etc-in PCC indicated Resident #4 had a full code advance directive. A nursing progress note was entered on 02/14/20 at 5:17 PM indicating Resident #4 was experiencing increased confusion and had 3 episodes of choking during the shift. The resident indicated she couldn't breathe and asked to go to the hospital. The Medical Doctor (MD) was contacted and ordered that Resident #4 be sent to the emergency room (ER) for evaluation. A physician order [REDACTED].#4 was to be transferred to the ER for evaluation of shortness of breath, altered mental status and choking. A telephone interview was conducted on 03/11/20 at 1:06 PM with the emergency room (ER) physician who provided care to Resident #4 on 02/14/20. The ER physician indicated that Resident #4 had been sent to the emergency room with a yellow DNR form in addition to a face sheet which indicated Resident #4 was a full code. The ER physician reported that Resident #4 aspirated (breathed a foreign object into her airway), while in the ER. The ER physician was unsure if it was appropriate to intubate her and had to call the facility to request additional documentation to clarify code status. Once the ER physician clarified that Resident #4 was a DNR with comfort measures only (which included no antibiotics or intravenous (IV) fluids) ER staff were ordered to provide only comfort measures. On 03/11/20 at 4:48 PM Nurse #1 printed a copy of the face sheet that was sent with Resident #4 to the ER. Review of the face sheet revealed a column that read Code Status: FULL CODE in capital letters. The face sheet was titled Admission Record and did not specify a date of input or any dates to indicate it had been updated. An interview conducted with Nurse #1 on 03/04/20 at 4:50 PM who had prepared the paperwork for Resident #4's transfer to the ER revealed she sent a copy of the medication orders, the DNR form, the residents latest vitals, a face sheet, an order summary and a progress note regarding the resident's status. Nurse #1 was not present when the ER called the facility to clarify code status but heard about it later. Nurse #1 indicated she was not aware the face sheet listed an incorrect code status. A telephone interview was completed with Nurse #2 on 03/12/20 at 9:44 AM. Nurse #2 was working the night the ER physician called the facility to confirm code status. Nurse #2 reported that he confirmed for the ER physician that Resident #4 was a DNR and that the ER physician requested a copy of the MOST form. Nurse #2 read her the MOST form and then faxed it to the ER. On 03/12/20 at 8:38 AM an interview was completed with the MDS Coordinator who indicated that the only time she updated the face sheet in PCC was to correct a social security number or something along those lines. The MDS Coordinator reported that the face sheet was generally filled in by the clinical liaison's upon admission. The MDS Coordinator further reported that she was unaware the code status was even listed on the face sheet on PCC and that she had never updated the code status there. A telephone interview was completed on 03/12/20 at 8:47 AM with the Clinical Liaison for the facility who indicated that upon admission she filled in the demographics, insurance information, admitting [DIAGNOSES REDACTED]. The Clinical Liaison indicated that she would put the code status from the hospital into the face sheet but after the initial admission process was completed, she did not go back in to make changes. The Clinical Liaison reported that after a resident was admitted , it was up to nursing staff to update the electronic chart. An interview was held with the Director of Nursing (DON) on 03/12/20 at 12:10 PM who indicated that she was not aware the Admission Record that was used as a face sheet had the code status listed on it. The DON indicated the code status shown there was entered on admission and she was not sure of how to correct it. The DON agreed that she should have noticed that the face sheet was conflicting and that it should have been consistent with current orders. The DON indicated that staff at the facility were expected to check physician orders [REDACTED]. She stated her expectation was for outside facilities to check the incoming paperwork for code status on golden rods, the order summary report and a MOST form if it had been included (although it was not required). The DON indicated that the face sheet was supposed to go to outside facilities with patients but that she was unaware there was the potential for an outdated code status to appear on the form. On 03/12/20 at 1:17 PM an interview was completed with the Administrator who reported that it was her expectation that there was consistency across the code status locations and that it was always up to date. 2. Resident #17 was admitted on [DATE] with a [DIAGNOSES REDACTED].#17 was cognitively intact. Review of the medical record revealed a care plan initiated 09/06/16 which indicated Resident #17 had an advance directive of DNR. The physician orders [REDACTED].#17 had a DNR advance directive. Observation of Resident #17's physical chart revealed there was no DNR form in his physical chart. An interview was completed with Nurse #3 on 03/12/20 at 10:34 AM who indicated that the physical chart should have a DNR form and a MOST form in it which is where she generally looked for code status. Nurse #3 observed Resident #17's chart with the surveyor on 03/12/20 at 10:34 AM and confirmed that neither a DNR or MOST form were in the chart. An interview was completed with the DON on 03/12/20 at 12:10 PM who indicated that golden rods (DNR forms) were kept in resident's physical charts. The DON indicated that Resident #17 had recently went out to the hospital and likely did not return with his golden rod DNR form. The DON stated that although the code status was listed in the physician orders [REDACTED]. An interview was completed with the Administrator on 03/12/20 at 1:17 PM who stated that if a resident was a DNR the expectation was that there is a DNR/golden rod form in their chart.

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