STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335724	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SILVERCREST	144 45 87TH AVENUE JAMAICA, NY 11435

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 staff interviews and record review conducted during an abbreviated survey (NY 532), the facility did not ensure that a resident's representative wish for Do not Resuscitate (DNR) for a resident was honored. This was evident in 1 out of 5 residents sampled (Resident #1). Specifically, Resident #1's representative requested DNR for Resident #1 but the facility delayed the process in obtaining the DNR approval for her. Resident #1 was found unresponsive and without pulse 33 days after admission on [DATE], and Cardio-Pulmonary Resuscitation (CPR) was performed on her for two to three minutes. The Findings are: Review of the Facility's Policy on Family Health Care Decision Act revised [DATE] documented that if a patient has a history of receiving services for or has mental [MEDICAL CONDITION] or a developmental disability; the OMRDD regulations apply to the patient. The Primary Physician, Nursing and Social Worker will review transfer paperwork upon admission to determine existence of any DNR/MOLST forms. The law allows those closest to a resident who lacks capacity to make decisions for the resident. Review of the Facility's Policy and Procedure on Code 99- Basic Life Support revised [DATE] documented that if a resident is suddenly unresponsive, activate Code 99, check for purple arm band indicating DNR. If the resident is DNR do not proceed. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated [DATE] identified the resident's short- and long-term memory as unable to determine. The resident's cognitive skills for decision making was coded as severely impaired. The resident was totally dependent of staff with her Activities of Daily Living (ADL) needs. An Advance Directives Care Plan initiated on [DATE] documented that Resident #1 was full code and had no Do not Resuscitate(DNR) or Health Care Proxy(HCP). The interventions included provide family with information about advance directives. Review of the Hospital Discharge Instructions dated [DATE] at 11:25AM documented Resident #1's code status as DNR/ Do Not Intubate (DNI). Review of the Medical Orders for Life Sustaining Treatment (MOLST) form signed by Hospital Physician dated [DATE] at 12:39PM noted Do not Resuscitate (DNR) & Do not Intubate (DNI) checked off. A Social Services Progress Note dated [DATE] at 4:13PM documented that the resident was admitted with DNR/DNI signed by Hospital Physician. Per document the resident's aunt is the closest relative and made the decision. Social Worker (SW) contacted the resident's aunt and explained to her that there is a process with the Office of Mental [MEDICAL CONDITION] and Developmental Disabilities (OMRDD) before she would be able to sign DNR. An undated and incomplete MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities Form checked off that Resident #1's aunt was an actively involved family member and requested DNR and DNI for Resident #1. A Nursing Progress Note dated [DATE] at 12:37AM documented that at start of shift during round around 11:10PM, she was called to check the resident by Certified Nursing Assistant (CNA). The resident was found unresponsive and without vital signs. DNR status was verified . A Respiratory Therapy Progress Note dated [DATE] at 4:56PM documented that she responded to the code and found the resident unresponsive. The resident had no respiration and pulse. CPR was initiated. The resuscitation was stopped due to DNR/DNI status. Review of the Facility's Investigation dated [DATE] documented that the resident was observed to be unresponsive during rounds on [DATE] at 11:10PM. The Primary Care Staff Nurse initiated CPR as per the facility's protocol. The resident had no purple band or physician's orders [REDACTED]. The assigned nurse then checked and saw hospital transfer documents and a signed MOLST form indicating DNR. CPR was stopped and the resident was pronounced dead at 11:28PM. The resident's aunt, who is not her legal guardian initiated the DNR in hospital. The facility's Social Worker (SW) realized that the DNR needed approval from the Office of Mental [MEDICAL CONDITION] and Developmental Disabilities (OMRDD). The resident was a member of the MRDD group and always had a Personal Aide from the Group Home by her bedside. The root cause of the occurrence was conflicting information in the hospital transfer information. The facility plans to remove all inactive MOLSTs forms from residents' charts. Certified Nursing Assistant #1 (CNA#1) was interviewed on [DATE] at 12:30PM and stated that she was assigned to the resident on [DATE] during the 11:00PM-7:00AM shift. She made rounds in the resident's room about 11:10PM and noted the resident was unresponsive and there was no rise and fall of her chest. The companion from the Group Home was sitting at the resident's bedside. She left the room and called RN #1. The Social Worker was interviewed on [DATE] at 12:45PM and stated that the Registered Nurse who admitted the resident alerted her of the DNR/DNI on the Hospital Discharge Summary and the MOLST Form. She reviewed the resident's hospital discharge information and MOLST form and notified the resident's aunt that the MOLST was not valid due to the resident being under OMRDD. The resident's aunt told her that she wanted the resident to have DNR/DNI. She started the checklist process for the resident to have approval for the DNR/DNI sometime in December (she couldn't remember the date and no documentation noted in resident's record). She spoke to a representative from OMRDD and the representative told her that any facility Physician who was OMRDD certified could have signed the form, the facility has an OMRDD certified Physician, but he was on vacation. She did not contact the OMRDD further. She discussed the DNR/DNI issue with the Director of Social Services (DSS). RN #2 was interviewed on [DATE] at 1:15PM and stated that she was assigned to the resident on the ,[DATE] shift on [DATE]. She last saw the resident about 10:45PM prior to her expiration. RN #1 called her after the resident was found unresponsive, RN #1 called Code 99. She went to the desk to verify code status and saw the Hospital Discharge and MOLST form documented DNR/DNI. She alerted the code team about ,[DATE] minutes after they went into the resident's room. Registered Nurse #1(RN #1) was interviewed on [DATE] at 1:40PM and stated that she was assigned to the resident during the ,[DATE] shift on [DATE]. She responded to the resident's room at 11:10PM and found her unresponsive. She called for help then checked the resident's vital signs, which were absent. The resident had no DNR order in EMR and she couldn't recall seeing a purple armband. She called Code 99 then assisted with the initiation of CPR. It was about 2 minutes when RN #2 alerted them that she saw that the resident had DNR/DNI in her chart. They stopped the resuscitative measures. The Director of Social Services (DSS) was interviewed on [DATE] at 4:00pm. She stated that the Social Worker made her aware that the resident's hospital discharge instructions and the MOLST Form documented that the resident was DNR/DNI. She further stated that the hospital DNR/DNI and MOLST were invalid because it had to be approved by the OMRDD. She went on to say that the SW was in the process of getting the necessary paperwork signed by an OMMRD certified Physician. She stated that it was delayed because the Physician was on vacation. The Medical Director of the Office of Developmental Disabilities Services where the SW stated that she contacted was interviewed on [DATE] at 3:20PM. She stated that she received a call from the Social Worker on [DATE] regarding Resident #1's DNR/DNI. She found out that her office was not responsible for Resident #1, since Resident #1 did not reside in her district prior to being admitted to the facility. She told the SW to contact the Agency or Metro Developmental Disabilities Regional Office. She further stated that according to the regulation, the Office of People with Developmental Disabilities (OPWDD) should be notified of a DNR/DNI request at least 48hrs in advance. She added

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

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.

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F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) that if the MOLST checklist form is completed, the OPWDD reviews it and approves the DNR/DNI in a short time. It is usually approved by the following day. The Vice President of Nursing was interviewed on [DATE] at 9:40AM. She stated that the facility's investigation concluded that Resident #1's admission DNR was not valid. The facility reviews all DNRs and DNIs for validity on admission. She stated that when a resident is admitted with affiliation from the OPWDD, the assigned Social Worker would reach out to organization. If the Social Worker is having difficulty, she would network with the Director of Social Services. As corrective measures, DNRs/DNIs will be validated by the Nursing Supervisor on Admission. The Nursing Supervisor will contact the Social Worker and the DNR/DNI status will be clarified with 24hours. She further stated that every resident with a level 2 Preadmission Screen will have their DNR/DNI pre-screened and verified with the OPWDD before admission to the facility. The Medical Director was interviewed on [DATE] at 10:20AM and stated that the facility's OMRDD certified Physician was on vacation for two weeks . The Physician's vacation began in the two weeks just before Resident #1 coded. The Physician was available prior to that time. He was not informed of the delay in getting Resident #1's DNR approved. The facility only has one OMRDD certified Physician. He added that going forward, the facility needs to look into getting more OMRDD certified Physicians. 415.3 (e) (1) (ii)