STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335564	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ONTARIO CENTER FOR REHABILITATION AND HEALTHCARE	3062 COUNTY COMPLEX DRIVE CANANDAIGUA, NY 14424

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 interviews and record reviews conducted during an Abbreviated Survey (complaint #NY 470), it was determined that for one (Resident #1) of three residents reviewed for advance directives, the facility did not ensure that there was an organized, effective system to ensure that the resident's wishes regarding Cardiopulmonary Resuscitation (CPR) and Do Not Resuscitate are initiated and implemented according to their wishes. Specifically, the resident completed Medical Orders for Life Sustaining Treatment (MOLST) documenting their wishes for Do Not Resuscitate (DNR). The MOLST was not signed by the physician, and medical orders were not written for a DNR. This is evidenced by the following: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident was cognitively intact. The facility policy, Advance Directives, last revised February 2019, revealed that upon admission the admitting nurse will verify a resident's code status and the Social Worker or designee will inquire of the resident or their representative, about the existence of any written advance directives. The nurse or designee will notify the attending physician of the resident's code status and any advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. Review of the Hospital Discharge Summary, dated [DATE], and a Nurse Practitioner note, dated [DATE], revealed the resident's current code status as of [DATE] was DNR with mechanical ventilation (artificial breathing) permission. An electronic physician order, dated [DATE], included CPR as current status that was verified by a MOLST. The Medication Administration Records for [DATE] and [DATE] both included the advance directive for the resident was CPR. A physician progress notes [REDACTED]. A MOLST form, signed by the resident and witnessed by the Director of Social Work (SW) and the Registered Nurse (RN) Manager on [DATE], revealed the resident chose DNR wishes and to not allow ventilation. The area designated for physician review and signature was blank. A nursing progress note, dated [DATE], revealed that the resident was found slumped over forward and cold and was assessed for vital signs with none present. It was noted that the resident was an attempt CPR status according to the electronic medical record, so 911 was called, CPR was initiated and continued until Emergency personnel arrived, and the resident was pronounced dead. In a telephone interview, conducted on [DATE] at 12:48 p.m., the Licensed Practical Nurse stated he initiated CPR for Resident #1 at the direction of the RN. He said the RN checked the computer and stated the resident was a full code (initiate CPR). When interviewed via telephone on [DATE] at 1:45 p.m., the Director of SW stated that she reviews the MOSLT with the resident, signs the MOLST with nursing, and adds the advance directive to the Comprehensive Care Plan. The Director of SW stated that nursing then puts the order into the computer and places the MOLST in front of the paper chart for the physician to sign. When asked about the MOLST for Resident #1, the Director of SW said she remembered completing the MOLST with the resident and RN Manager and that the resident's wishes were DNR. She said she had completed an audit in [DATE] and had noted that the resident's order in the computer was wrong (indicating CPR) and had asked the RN Manager to correct the error. (10 NYCRR 415.3(e)(1)(ii))
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during an Abbreviated Survey (complaint #NY 470), it was determined that for one (Resident #1) of three residents reviewed for Quality of Care, the facility did not ensure potential violations of abuse, neglect, and mistreatment, including the unexpected death of a resident, were investigated completely. Specifically, Resident #1 expired unexpectantly, and the facility could not provide evidence that investigations were completed related to potential issues of neglect. This is evidenced by the following: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated [DATE], revealed the resident was cognitively intact. The facility policy, Abuse, dated February 2019, defined neglect as the failure to provide goods or services. The policy included reports of suspected abuse, neglect, mistreatment shall be promptly investigated. An electronic physician order, dated [DATE], included Cardio-Pulmonary Resuscitation (CPR) as the resident's code status in the event of death. A Nurse Practitioner progress note, dated [DATE], revealed that the code status for the resident was Do Not Resuscitate (DNR, allow natural death) with ventilation (artificial breathing) permitted. Review of a Medical Orders for Life Sustaining Treatment (MOLST) form, signed by the resident and witnessed by the Social Worker and Registered Nurse Manager on [DATE], revealed the resident chose a code status for DNR with no ventilation permitted. The MOLST form was not signed by a physician. Review of the resident's bowel records, dated [DATE] through [DATE], revealed no documented bowel movements for 12 shifts, one small bowel movement, and then no bowel movements for an additional 13 shifts. Review of the [DATE] Medication Administration Record [REDACTED]. Review of a progress note, dated [DATE] and signed by the Nurse Practitioner, revealed the resident was seen for a routine visit, was found to have acute abdominal distention, had complained of loose stools, and per staff had no bowel movements for several days. A flat plate x-ray of the abdomen was ordered. A nursing progress note, dated [DATE], documented that the resident was found without vital signs and CPR was initiated. In an interview conducted on [DATE] at 2:00 p.m., the Administrator stated that investigations were initiated related to the resident's unexpected death, bowel protocol not initiated, and the incorrect code status being initiated. The Administrator stated she was in the facility on [DATE] and completed education with the staff regarding residents' code status. The Administrator stated the Corporate Director of Clinical Services completed an investigation related to the resident's bowel status in conjunction with the Director of Nursing, but she could not find any documented evidence. In a telephone interview conducted on [DATE] at 10:21 a.m., the Corporate Director of Clinical Services stated that she did review an investigation and provided an action plan related to the facility's code status not followed, but she could not provide documented evidence of the investigation or its conclusion. She said she could not recall the bowel issues. In a telephone interview conducted on [DATE] at 11:47 a.m., the former Director of Nursing stated that she was not involved in an investigation related to either bowel protocol not being followed or incorrect code status initiated for Resident #1 but thought the Corporate Director of Clinical Services completed it. (10 NYCRR 415.4(b)(2))
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during an Abbreviated Survey (complaint #NY 470), it was determined that

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) for one (Resident #1) of three residents reviewed for quality of care, the facility did not ensure that each resident received treatment and care in accordance with professional standards of practice and the physician orders. Specifically, Resident #1's bowel status was not monitored, and bowel medications were not administered per physician orders. This is evidenced by the following: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 8/22/19, revealed the resident was cognitively intact. The facility policy, Bowel Management, dated May 2019, revealed that on admission a bowel assessment/evaluation will be performed. The Certified Nursing Assistant (CNA) will document the resident's bowel movement status every shift in the electronic medical record to include number, size, and consistency, and report to the nurse or unit manager any residents who had a small or no bowel movement for nine shifts. The nurse will review the documentation at the beginning of each shift, and if no bowel movement in three days (72 hours) the nurse will initiate the bowel regime, which has been set by the Medical Director to include Milk of Magnesia (laxative), if ineffective after one day, administer [MEDICATION NAME] (laxative), and if ineffective after one day, administer a Fleet's enema. If no bowel movement after the Fleet's, the physician should be notified. Initiation of the bowel regimen and its effectiveness are to be reported on the 24-hour report for follow up on all three shifts. The admission nursing evaluation, dated 8/15/19, revealed the resident reported having bowel movements every one to two weeks only. The electronic physician orders, dated 8/15/19, included [MEDICATION NAME] every 24 hours as needed and [MEDICATION NAME] (laxative) 17 grams every 24 hours as needed for bowel management. Review of the bowel records, 8/15/19 through 9/15/19, revealed the only documented bowel movements between 8/15/19 and 8/23/19 (20 shifts) was a small loose bowel movement on 8/19/19, between 8/29/19 and 9/4/19 (21 shifts) a small bowel movement on 9/4/19, and between 9/6/19 and 9/15/19 (27 shifts) a small bowel movement on 9/10/19 (total of three bowel movements in 31 days). Review of the Medication Administration Records (MARs), dated 8/15/19 through 9/15/19, revealed neither the as needed [MEDICATION NAME] or [MEDICATION NAME] laxatives had been administered or any bowel regime (per the policy) had been initiated. A physician order, dated 9/12/19, added Senna plus (stool softener plus laxative) ordered at bedtime for bowel management. The September 2019 MAR indicated [REDACTED]. A Nurse Practioner (NP) note, dated 9/13/19, included the resident was seen for a routine visit during which the resident stated they were having loose stools, and according to staff the resident had not had a bowel movement for several days. The resident's abdomen was firm and distended and a flat plate of the abdomen was ordered to rule out obstruction. Physician orders, dated 9/14/19 at 8:13 a.m., included to administer a Fleet mineral oil enema for possible bowel obstruction, and at 8:44 a.m., an order to give [MEDICATION NAME] (laxative) for possible bowel obstruction. The September 2019 MAR indicated [REDACTED]. There was no nurse's note to explain why the enema was held. Review of the 24-hour report sheets, from 8/15/19 through 9/15/19, did not include that Resident #1 had any bowel protocol initiated. Interviews conducted on 3/6/20 between 10:00 a.m. and 10:30 a.m. included the following: a. Three CNAs stated they documented the size and consistency of the resident's bowel movements in the computer, and if a resident had not had a bowel movement in three days, it would be reported to the nurse. b. The Licensed Practical Nurse (LPN) stated if the resident had not had a bowel movement in more than three days, the nurse and CNA should receive an alert on the computer dashboard, bowel medications would be administered, and the physician notified. The LPN stated if an as needed bowel medication was administered, the resident would be placed on the 24-hour report sheet. In an interview on 3/6/20 at 12:15 p.m., the NP stated when a resident has not had a bowel movement in three days, as needed medications should be administered and the medical provider should be notified. The NP stated if the resident truly only moved their bowels every one to two weeks, they would try to regulate the resident's bowel movements more. The NP stated that she would expect the bowel medications ordered on [DATE] to be administered within two to four hours of the order if medications were in house. In a telephone interview on 3/6/20 at 12:47 p.m., the Medical Director stated the provider should be notified when a resident has not moved their bowels in three days and the bowel protocol should be initiated. (10 NYCRR 415.12)