STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115659	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Ctr of Lawrenceville	210 Collins Industrial Way Lawrenceville, GA 30045

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, resident and staff interviews, and review of the facility policies titled, Cardiopulmonary Resuscitation (CPR) Policy and Advance Directives and Advance Care Planning, the facility failed to communicate and ensure preference for the change in code status from full code to do not resuscitate (DNR) was updated in the medical record for one of three sampled residents (R) (R1). The deficient practice had the potential to deny the residents and/or representatives the opportunity to direct health care in the event that they were to become unable to make decisions or communicate health care preferences. Findings include: Review of the facility policy titled Cardiopulmonary Resuscitation (CPR) Policy last revision date of [DATE] documented under Definitions: Do Not Resuscitate (DNR) Order – refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. Existence of an advance directive does not imply that a resident has a DNR order. The medical record should show evidence of documented discussions leading to a DNR order. Review of the policy titled Advance Directives and Advance Care Planning, revised [DATE] and reviewed [DATE], documented under Procedure: . 6. Residents may revise an advance directive either orally or in writing. With an oral reversal, charting is due immediately, the physician is notified immediately, an immediate notation is made on the care plan, and an immediate entry is made in the medical record. With written reversals, the physician is notified, and the plan is permanently adjusted. The physician must give an order for any changes in the advance directives. Review of the electronic medical record (EMR) revealed R1 was admitted pertinent diagnoses including but not limited to metabolic encephalopathy, progressive neurological conditions, non-Alzheimer's dementia, and malnutrition (protein, calorie), risk of malnutrition. Review of R1's admissions Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicates R1 had severe cognitive impairment. Section GG, Functional Status, revealed R1 required extensive assistance for activities of daily living (ADLs) with one or more-person assistance. Review of R1's care plan dated [DATE] indicated a problem of R1 prefers to remain a full code. Goals included but not limited to R1 wish to remain a full code will be honored. Interventions included but not limited to code status will be reviewed on a quarterly basis and PRN (as needed), Resident has decided to remain a Full Code . (continued on next page)

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	Review of the Physician's Orders for R1 included but was not limited to: Order dated for [DATE] FULL CODE, Verbal, Active. Interview on [DATE] at 2:27 pm with R1revealed she was admitted on [DATE] and a discussion with Admissions revealed she had to make a decision on whether R1 would be a DNR or not. She revealed she did have the DNR documents that she signed. She stated the staff of the facility lied and stated staff did not know about the DNR because two doctors had to sign off on it to be a DNR. R1 did not understand why the facility coded her as something different than what was talked about during the planning meeting. Interview on [DATE] at 1:27 pm with the Administrative Assistant revealed she could not find the note in the EMR which should talk about advanced directives for R1. She further revealed the process the facility followed for advanced directives was at admission and they [the facility] would need to go over the forms and sign baseline care plans, the physician order for life sustaining treatment (POLST), and ask questions regarding discharge planning depending on the person and if they were here long term or short term. Phone Interview on [DATE] at 1:44 pm with the Admissions Director revealed she explained the advanced directive process to R1 and family, and specifically R1's daughter became upset and needed to speak with several people and left the POLST un-signed. The Admissions Director revealed that if the POLST was un-signed, the resident was a full code. If they do become a DNR, then the resident would be a full code until it was signed off by the doctor. She further revealed that all families were explained this on admission. She further stated that once she had the [signed] POLST, it went to Social Services to make sure the doctor signed it. She was not aware of the timeframe it took for the doctors to sign it. When asked why the POLST was not dated, she revealed initially she was told the POLST was to be dated once the admission was completed, however, if family members discussed it and a choice was not made, the recommendation was for the family to sign, then call/follow up about their decision, then it was dated and given to Social Services. She further revealed that she felt the daughter came in after hours and completed the POLST form which more than likely got misplaced in a box. Interview on [DATE] at 2:05 pm with the Social Services Director revealed when she received a POLST form that was signed, she had a responsibility of getting it signed by the physicians. Once it had the physician signature, she would scan the form into the EMR system and then send it to medical records and from there she would update the care plan. The timeframe was typically 48 to 72 hours. In the meantime, they had the morning clinical meeting and everyone was made aware of the code status change. When she received the POLST, typically they were dated and since the POLST for R1 was not dated, she revealed she would ask the Admissions Director but she could not recall what happened with this one. Even if it was the wish of the family to have their loved one as a DNR, if it was not signed, it was not valid. She revealed she believed it was signed the day before and would only make a note once the POLST was signed by the physician. She revealed the facility did not put advanced directive decisions in the baseline care plan and was not sure if there was a section for advance directives in the care plan. Any resident that was admitted to the facility would be a full code, even on the baseline care plan, until the POLST was signed by either two physicians or a physician and the resident or someone authorized to sign for the resident. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:25 pm with the Administrator revealed the resident would still be a full code if the appropriate documentation had not been received upon admission. The Administrator revealed she was un-sure the amount of time the process would take for the doctors to sign the POLST however, the doctors do come in the facility for the initial visit within 72 hours and would collaborate with the Interdisciplinary Team (IDT) but she was not sure if the doctors were actually a part of the baseline meeting. The Administrator further revealed Social Services and Admissions would collaborate and bring everyone together to discuss the plan for his or her stay.