STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335437	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellicott Center for Rehabilitation and Nursing	200 Seventh Street Buffalo, NY 14201

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** 43785 Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00359366), the facility did not ensure that all residents had the right to formulate advanced directives that would be honored for one (Resident #1) of six residents reviewed. Specifically, Cardiopulmonary Resuscitation (CPR) was implemented for Resident #1 who had a MOLST (Medical Orders for Life Sustaining Treatment) identifying the resident's wishes as Do Not Resuscitate (DNR). The finding is: The policy and procedure titled Advance Directive and State Specific Medical Orders for Life Sustaining Treatment-New York dated [DATE] documented residents have the right to formulate an advance directive and to request, refuse and discontinue treatments. An advance directive is a written statement of a person's wishes regarding medical treatment made to ensue those wishes are carried out should the person be unable to communicate them to a physician. New York State uses the Medical Orders for Life-sustaining Treatment. A physician order shall be obtained and entered into the electronic medical record following consent of the resident/representative. The policy and procedure titled Code Blue/CPR (Cardiopulmonary Resuscitation) dated [DATE] documented the facility will provide emergency cardiopulmonary resuscitation in accordance with the resident end of life determinations, example: Medical Orders for Life Sustaining Treatment (MOLST). The policy documented that cardiopulmonary resuscitation will be initiated upon recognition of cardiopulmonary arrest in accordance with the resident code status (full code). The policy and procedure titled Resident Identification dated [DATE] documented a resident identification system is used to assist facility personnel to accurately identify a resident. The facility had adopted a photo and/or wristband identification system to help assure that medication, treatment, and services are administered to the correct resident. Resident #1 had diagnoses that included malignant neoplasm of the brain, lung, and lymph nodes, chronic obstructive pulmonary disease (COPD), and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #1 was cognitively intact and was understood. The Medical Orders for Life Sustaining Treatment (MOLST) form dated [DATE] at 12:18 PM documented Resident #1's advanced directive status as DNR (do not resuscitate) and a DNI (do not intubate). (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	An updated Medical Orders for Life Sustaining Treatment form dated [DATE] at 12:57 PM, documented Resident #1's advanced directive status as DNR (do not resuscitate) and a DNI (do not intubate). The form was updated to include not send to the resident to the hospital and was comfort measures only. The comprehensive care plan dated [DATE] documented Resident #1 had a Medical Orders for Life Sustaining Treatment (MOLST) form in place. The Medical Providers Orders dated [DATE] documented do not attempt resuscitation and do not intubate. A Progress Note completed by the Director of Social Work dated [DATE] at 12:14 PM, documented they spoke with Resident #1 and their Health Care Proxy (HCP) who wanted the Medical Orders for Life Sustaining Treatment form to reflect: do not attempt resuscitation, do not intubate with limited medical interventions. A Progress Noted dated [DATE] at 4:30 AM, the Director of Nursing documented on [DATE] at 4:00 AM Resident #1 was discovered unresponsive with no evidence of vital signs (heartbeat, respirations). Nurse was called to the room, the Medical Orders for Life Sustaining Treatment verified by the nurse and cardiopulmonary resuscitation was initiated. 911 (emergency medical service) was called and arrived at which time it was discovered that Resident #1 actually had a do not resuscitate status. The note documented the paramedics did not continue cardiopulmonary resuscitation and Resident #1 expired at 4:00 AM. The facility investigation dated [DATE] documented that on [DATE] at approximately 3:50 AM Resident #1 was found without vital signs and a code blue was called. Licensed Practical Nurse #1 had erroneously reviewed Resident #2's (roommate) Medical Orders for Life Sustaining Treatment form at time of event, not Resident #1's form. The conclusion of the investigation documented Licensed Practical Nurse #1 failed to confirm identity of resident prior to initiating cardiopulmonary resuscitation. During a telephone interview on [DATE] at 1:20 PM, Certified Nurse Aide #1 stated around 3:45 AM on [DATE] they went to go check on Resident #1. They stated Resident #1 looked like they were sleeping but did not wake to their voice. Certified Nurse Aide #1 stated they shook Resident #1's arm, they did not respond, and they noted Resident #1 was not breathing. Certified Nurse Aide #1 stated they notified Licensed Practical Nurse #1 that Resident #1 (using the resident's name) was not responding or breathing. Certified Nurse Aide #1 stated that Licensed Practical Nurse #1 preformed cardio-pulmonary resuscitation on Resident #1 until the paramedics arrived. Certified Nurse Aide #1 stated they were not aware Resident #1 had a do not resuscitate order until after the event was over. During an interview on [DATE] at 2:11 PM, the Assistant Director of Nursing stated the Certified Nurse Aides were not allowed to initiate cardio-pulmonary resuscitation and were educated that when they find a resident unresponsive, they were to immediately notify a nurse. The Assistant Director of Nursing stated that in general orientation all staff members were taught to identify a resident by looking at their picture in the electronic medical record. They stated based on the resident population the facility does not utilize name bands as identification because the residents do not want to wear them, remove them, or place them on other things. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:08 PM, Licensed Practical Nurse #1 stated around 3:50 AM on [DATE] they were alerted by Certified Nurse Aide #1 they had an unresponsive resident and thought they could be dead. Licensed Practical Nurse #1 stated they went to Resident #1's room to look at the resident. The resident had no pulse, no respirations, was gray in color, their body was cold and it had rigor (rigidity-when the body starts hardening after death). Licensed Practical Nurse #1 stated Certified Nurse Aide did not tell them the resident's name at the time but when they went into the room there was not another resident in the room. Licensed Practical Nurse #1 stated they went to the nurses desk and pulled the paper medical record for that room, assuming the room was not occupied with another resident. They stated the Medical Orders for Life-Sustaining Treatment form they looked at, indicated cardio-pulmonary resuscitation. Licensed Practical nurse #1 stated they called 911 on the way back to the room and began cardio-pulmonary resuscitation (CPR). Licensed Practical Nurse #2 arrived to assist, and they both performed chest compressions until the Emergency Medical Technicians arrived. Licensed Practical Nurse #1 stated the Emergency Medical Technicians did not perform cardio-pulmonary resuscitation on Resident #1 because they stated rigor had set in and they pronounced Resident #1 deceased . Licensed Practical Nurse #1 stated after they returned from a break, Licensed Practical Nurse #2 notified them that Resident #1 had a do not resuscitate order and CPR (cardiopulmonary resuscitation) should not have been initiated. Licensed Practical Nurse #1 stated in error they looked at the Medical Orders for Life-Sustaining Treatment form for Resident #2 (roommate) not Resident #1. They stated they went into code mode but should have taken a moment and verified the resident to their picture in the electronic medical record prior to starting cardio-pulmonary resuscitation as the facility trained them to do. During a telephone interview on [DATE] at 6:58 AM, Licensed Practical Nurse #2 stated on [DATE] around 3:45 AM they were alerted by a Certified Nurse Aide (unknown name) there was a code blue. They stated they got the crash cart (cart with emergency supplies) and when they arrived at Resident #1's room, Licensed Practical Nurse #1 was about to begin chest compressions to Resident #1. Licensed Practical Nurse #2 stated 911 was already called and they worked along with Licensed Practical Nurse #1 to provide chest compressions until the Emergency Medical Technicians arrived. Licensed Practical Nurse #2 stated they did not verify who the resident was, nor the residents advance directive orders prior to initiating CPR. Licensed Practical Nurse #2 stated after the event they had asked a Certified Nurse Aide (unknown name) how was the resident (using the name of Resident #2) during the beginning of the shift and the Certified Nurse Aide replied that was not Resident #2, that was Resident #1. Licensed Practical Nurse #2 stated at that time they checked the Medical Orders for Life-Sustaining Treatment form for Resident #1 and realized an error had been made. They immediately called the Director of Nursing. Licensed Practical Nurse #2 stated Resident #1's advance directive wishes were not honored. They stated they should have verified the Medical Orders for Life-Sustaining Treatment form against the EMR (electronic medical record) and with the resident's picture in the EMR (electronic medical record) prior to performing CPR (cardio-pulmonary resuscitation). During an interview on [DATE] at 10:20 AM, the Director of Social Work stated Resident #1 should not have received cardio-pulmonary resuscitation because that was not their wishes, and Resident #1 choices were not honored. During a telephone interview on [DATE] at 10:53 AM, the Medical Director stated they were aware Resident #1 had received cardio-pulmonary resuscitation in error on [DATE]. The Medical Director stated it was disrespectful to Resident #1 that they had cardio-pulmonary resuscitation initiated because their wishes were not honored. They stated Resident #1 was alert and made the decision not to be resuscitated and a human error occurred. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 11:22 AM with the Director of Nursing and the Director of Clinical Operations was present. The Director of Nursing stated on [DATE] Resident #1 received cardio-pulmonary resuscitation in error when Licensed Practical Nurse #1 viewed the wrong resident's Medical Orders for Life-Sustaining Treatment form. They stated Licensed Practical Nurse #1 did not verify the picture in the electronic medical record prior to starting cardio-pulmonary resuscitation. They stated that Resident #1's wishes were not initially honored but ultimately were because no pulse or respiration were revived. The Director of Nursing stated prior to starting cardio-pulmonary resuscitation on a resident staff should have verified by confirming with the picture in the electronic medical with the physicians orders and the MOLST (medical orders for life sustaining treatment). The Director of Clinical Operations stated they agreed with what was stated by the Director of Nursing. Based on the following corrective actions it was determined the facility implemented corrective actions to correct the non-compliance. -Licensed Practical Nurse #1 was placed on administrative leave on [DATE]. They were reeducated on proper identification of residents prior to initiating cardiopulmonary resuscitation. -Licensed Practical Nurse #2 was given a training referral on verifying/confirm resident identity and Medical Orders for Life Sustaining Treatment prior to initiating cardiopulmonary resuscitation. -The Staff Educator and/or designee reeducated all licensed nurses on cardiopulmonary resuscitation management of events. Education included confirming identification prior to administering cardiopulmonary resuscitation. As off [DATE] 89% of licensed nurses were educated. As of [DATE] 100% of all nurses were re-educated. -A full house audit was completed of resident's photos in the electronic medical record. -A full house audit of all residents Medical Orders for Life Sustaining Treatment was completed to ensure they were available on nursing units. -Social Worker #1 completed an audit of all resident advance directive determination, Medical Orders for Life Sustaining Treatment, physician orders and do not resuscitate consent. -AD HOC PI (when necessary, Quality Assurance performance improvement) meeting was completed on [DATE] with the Medical Directors participation. 10 NYCRR 400.21