STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335489	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningstar Residential Care Center	17 Sunrise Terrace Oswego, NY 13126

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 - Immediate jeopardy to resident health or safety 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. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the abbreviated survey (IQIES #2572456), the facility failed to establish consistent mechanisms for documenting and communicating a resident's choice regarding advance directives to the staff responsible for the resident's care for one (1) of three (3) residents, Resident #1. Specifically, Resident #1 was found without a pulse and without respirations, and staff did not initiate cardiopulmonary resuscitation (emergency procedure performed when someone's breathing or heartbeat has stopped) per the resident's wishes documented on their Medical Orders for Life Sustaining Treatment, resulting in the resident's death. Additionally, the facility failed to ensure there was a process for verification of medical orders related to residents' advance directives. The facility's failure to verify Resident #1's advance directives including the Medical Order for Life Sustaining Treatment form places all 104 residents in the facility who had advance directives in place at risk. This resulted in actual harm that was Immediate Jeopardy to residents' health and safety.Findings include:The [DATE] facility policy Physician Order Management Policy, documented advance directives must be entered using an order template search; it was the only way the system could identify the order as an advanced directive. New orders would be reviewed using a multiple nurse check approach on each shift and by the 11:00 PM - 7:00 AM night supervisor to ensure the new order met the basic prescribing standard and checked for transcription accuracy. The [DATE] facility policy Advance Directives, documented the Care Center would educate appropriate staff regarding advance directives. The Medical Orders for Life Sustaining Treatment form was the primary reference at the facility. Should the resident present as a repeat admission, with information that indicated there was an advance directive in the previous medical record, social services and/or nursing staff had the responsibility to review the existing advanced directive with the resident/significant other to validate its current status. Resident #1 had diagnoses of osteoarthritis of both knees, sepsis without septic shock (a life-threatening complication of an infection) and urinary tract infection. The [DATE] Minimum Data Set (an assessment tool) documented the resident had intact cognition, clear speech, could understand others and was understood, and had a urinary catheter. The [DATE] Medical Order for Life Sustaining Treatment form documented Resident #1's wishes were for Full Code (initiate cardiopulmonary resuscitation). The [DATE] Comprehensive Care Plan documented Resident #1 wished to have advance directive orders in place and refer to the Medical Orders for Life Sustaining Treatment form. Interventions were to notify the physician with changes and review annually. The [DATE] at 10:07 AM hospital discharge summary documented the resident was admitted for septic shock related to a urinary tract infection, had stabilized and was ready for discharge. The hospital discharge summary progress note did not reference the resident's advance directive status. The physician orders in the electronic medical record documented:- On [DATE] at 3:15 PM, a telephone order was created by Licensed Practical Nurse #9 for Resident #1's advance directives. The order documented Do Not Resuscitate (do not initiate cardiopulmonary resuscitation) and Do Not Intubate (do not use mechanical ventilation);- On [DATE] at 05:09 PM, Licensed Practical Nurse #10 confirmed the Do Not Resuscitate/Do Not Intubate physician order; and- On [DATE] at 10:00 AM, Physician #6 signed the order electronically. The [DATE] at 3:53 PM Nursing admission Assessment by Licensed Practical Nurse #10 documented Resident #1 had a Do Not Resuscitate/Do Not Intubate advance directive status. There was no documented evidence nursing staff reviewed advanced directives with the resident/significant other to validate its current status. A [DATE] at 5:54 PM nursing progress note by Licensed Practical Nurse #10 documented the resident was readmitted this shift, orders and Medical Orders for Life Sustaining Treatment were in place. There was no documented evidence the Medical Orders for Life Sustaining Treatment were in place. The [DATE] progress note by Nurse Practitioner #7 documented the resident was seen for a hospital follow up visit and their advanced directive wishes were discussed. Resident #1 was to remain a Full Code status. The [DATE] at 6:30 PM, Resident #1's Medical Order for Life Sustaining Treatment form was signed by Nurse Practitioner #7 and documented Full Code (initiate cardiopulmonary resuscitation). There was no documented evidence the advance directive order for Full Code was entered or verified in the electronic medical record. The [DATE] (untimed) facility investigation summary completed by the Administrator documented the facility discovered a transcription error by Licensed Practical Nurse #9 that resulted in the resident not receiving cardiopulmonary resuscitation per their wishes. Licensed Practical Nurse #4 responded, discovered the resident had no respirations or pulse, checked the physician orders (in the