

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Rome Memorial Hospital, Inc - R H C F		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 North James Street Rome, NY 13440	
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 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** The facility failed to provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice. Specifically, Resident #1's advanced directives were Do Not Resuscitate (allow natural death) and when they became unresponsive, the staff did not verify the Resident #1's advance directives per facility policy, and initiated cardiopulmonary resuscitation for approximately three minutes. Findings include: The 12/2025 revised facility policy, [Cardiopulmonary Resuscitation] Identification, documented All residents would have a [Medical Order for Life Sustaining Treatment] form completed upon admission. The [Medical Order for Life Sustaining Treatment] was the only identifier for code status ([Do Not Resuscitate] or Full Code). The [Medical Order for Life Sustaining Treatment] form should be located in the front of the resident's hard chart. Resident #1 had diagnoses including Parkinson's Disease and metabolic encephalopathy. The [DATE] Minimum Data Set assessment documented Resident #1 had severe cognitive impairment and was dependent for all activities of daily living and mobility. Resident #1's comprehensive care plan initiated on [DATE], and revised on [DATE] documented they had advance directives and a new [Medical Order for Life Sustaining Treatment] form was completed on [DATE]. Interventions included do not resuscitate and comfort measures only, and respect their wishes for advanced directives. The [DATE] Physician #3's order documented do not resuscitate and comfort measures. The Medical Order for Life Sustaining Treatment form, signed by the Health Care Proxy on [DATE], documented do not resuscitate, do not intubate, comfort measures only, do not send to the hospital, no feeding tube, no intravenous fluids, do not use dialysis, and determine the use of antibiotics when infection occurs. The Medical Order for Life Sustaining Treatment form was witnessed by the Director of Nursing and Licensed Practical Nurse #6. The [DATE] facility investigation, completed by the Administrator, documented on [DATE] at approximately 9:04 PM, Resident #1's Health Care Proxy reported to Licensed Practical Nurse #4 that Resident #1 was not breathing and did not have a pulse. Licensed Practical Nurse #4 responded immediately, and entered the room to assist the resident. They were not familiar with Resident #1's current plan of care. They activated the emergency call system and initiated cardiopulmonary resuscitation on Resident #1. Additional staff responded to the room, Licensed Practical Nurse #5 notified the facility supervisor and the attached hospital's emergency response team responded. During the resuscitative efforts, Resident #1's Health Care Proxy expressed they did not want Resident #1 to receive cardiopulmonary resuscitation or any other life sustaining interventions. Physician #7 (from the attached hospital's emergency response team) terminated resuscitative efforts, and Resident #1 was pronounced deceased at 9:08 PM with family at the bedside. During an interview on [DATE] at 3:28 PM, Licensed Practical Nurse #4 stated on [DATE], Resident #1's Health Care Proxy (resident's spouse) grabbed them and was quite frantic that Resident #1 stopped breathing, and to do whatever they could to save them. They did not know the resident's code status at the time. They went to the room and activated the emergency alert. They asked Resident #1's Health Care Proxy if the resident was a do not resuscitation or a full code. The Health Care Proxy stated they wanted the resident to be a full code and wanted everything done for them. Licensed (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 335563	If continuation sheet Page 1 of 2

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse #4 stated the instinct to save a life kicked in and they initiated cardiopulmonary resuscitation. They know they made a mistake and should have verified the advanced directives on the Medical Order for Life Sustaining Treatment form before initiating any treatment of this resident. They have been re-educated and will ensure they check the Medical Order for Life Sustaining Treatment in the future. During an interview on [DATE] at 9:44 AM, Physician #3 stated Resident #1's Medical Order for Life Sustaining Treatment form should have been reviewed prior to starting cardiopulmonary resuscitation. 10 New York Codes, Rules, and Regulations 415.12 Past non-compliance was identified. The Administrator was notified the facility's compliance date was [DATE]. The facility provided verification the following corrective actions were completed:- On [DATE], a complete and thorough investigation of Resident #1's death was completed. An audit of Resident #1's chart was completed to include verification of the Medical Order for Life Sustaining Treatment form, comprehensive care plan, and physician orders. - On [DATE], all nursing staff were educated on the process for advanced directives and code status. The training included verification of the Medical Order for Life Sustaining Treatment form, how to initiate the emergency response, and documentation post incident.- On [DATE], a full house audit was completed to verify all Medical Order for Life Sustaining Treatment forms were completed, that orders were entered correctly, and they had corresponding care plans with appropriate interventions. Continued audits occurred for new admission and re-admissions daily until [DATE].- On [DATE], a full house audit was conducted of all staff with current cardiopulmonary resuscitation certifications.- The facility planned to conduct code drills monthly for the next six months to monitor compliance.- Medical Order for Life Sustaining Treatment audits to be completed monthly for the next six months to ensure continued compliance.		