

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335724	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Silvercrest		STREET ADDRESS, CITY, STATE, ZIP CODE 144 45 87th Avenue Jamaica, NY 11435	

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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>43285</p> <p>Based on observations, record reviews, and staff interviews conducted during an Abbreviated Survey (NY00371678), the facility failed to ensure that a resident's Advance Directives were followed. This was evident for one (1) out of five (5) residents (Resident #1) sampled. Specifically, Resident #1, who was ventilator dependent, had a Medical Order for Life Sustaining Treatment indicating Do Not Resuscitate. Resident #1 was found without a pulse on 02/08/2025 and staff performed Cardiopulmonary Resuscitation that resulted in the return of spontaneous circulation. The resident was transferred to the hospital and remains there at this time. Based on several staff interviews, the resident received cardiopulmonary resuscitation efforts until staff members learned the resident was a Do Not Resuscitate. The resident was assessed after efforts were stopped and was found to have a pulse. Emergency Medical Services had previously been called and they transported the resident to the hospital.</p> <p>This resulted in Immediate Jeopardy Past Noncompliance with actual harm to Resident #1 with the likelihood for serious injury, serious harm, serious impairment, or death to all residents with Advance Directives.</p> <p>The findings include:</p> <p>The facility's Code 99-Basic Life Support Policy dated 08/31/2020, documented that the facility will provide basic life support for individuals who develop a sudden change in medical condition. The procedure documented if an individual is suddenly found unresponsive, activate Code 99. Staff are to verify Do Not Resuscitate status by checking physician orders, bring medication cart/laptop to location, review Advance Directive order in the Electronic Medical Record, a second person verify order/status, document verification on the code 99/RRT sheet, and if patient/resident is Do Not Resuscitate, do not proceed: provide comfort measures in a dignified manner.</p> <p>Resident #1 was admitted to the facility with diagnoses including respiratory failure, ventilator dependence, and tracheostomy.</p> <p>The Minimum Data Set (an assessment tool) dated 02/06/2025 documented Resident #1 had severe cognitive impairment.</p> <p>An Advance Directive Care Plan dated 02/07/2025 identified Resident #1 as Do Not Resuscitate.</p> <p>(continued on next page)</p>

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
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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An Accident/Incident Investigation report dated 02/08/2025 documented Resident #1's chart showed an order for Do Not Resuscitate and a plan of care for Do Not Resuscitate in place. On 02/08/2025, Respiratory Therapist #2 responded to the ventilator alarm and observed Resident #1 not responding at their baseline with vital signs present. Respiratory Therapist #2 attempted to stabilize the resident by clearing the airway through suctioning and Ambu-Bagging (provides respiratory support to patient). Resident #1 did not respond, and Respiratory Therapist #2 began chest compression to circulate the oxygenated blood to stabilize the resident which was not effective. Registered Nurse #1 was called and asked to call a code. Registered Nurse #1 responded, saw chest compressions being performed, and assisted. Additional staff responded and asked about advance directives, and it was noted that Resident #1 had a Do Not Resuscitate order in the chart. The investigation concluded that providing cardiopulmonary resuscitation was contrary to Resident #1's wishes and that this was human error isolated to two (2) contracted employees who provided chest compressions without first verifying the resident's code status as per policy.</p> <p>During an interview on 02/18/2025 at 11:05 AM, Respiratory Therapist #2 stated they were walking in the hallway when they observed a green light and heard Resident #1's ventilator alarm beeping. Respiratory Therapist #2 stated they went into Resident #1's room and observed Resident #1 unresponsive. Respiratory Therapist #2 stated Resident #1 was not their assignment; therefore, they instructed Respiratory Therapist #1 to check Resident #1. Respiratory Therapist #2 stated when Respiratory Therapist #1 checked Resident #1, the resident was unresponsive. Respiratory Therapist #2 stated Respiratory Therapist #1 called for Registered Nurse #1 to call Code 99 (a code when resident is unresponsive). Respiratory Therapist #2 stated they manually ventilated Resident #1 with an ambu-bag until Respiratory Therapist #3 took over. Respiratory Therapist #2 left Resident #1's room to check on another resident. Respiratory Therapist #2 stated when they came back to Resident #1's room, Resident #1 was on the ventilator and emergency services left with Resident #1 to the hospital. Respiratory Therapist #2 stated they do not recall who started the chest compressions.</p> <p>During an interview with Respiratory Therapist #1 on 02/18/2025 at 11:15 AM, Respiratory Therapist #1 stated at approximately 3:30 PM on 02/08/2025 they were alerted by Respiratory Therapist #2 that Resident #1 was unresponsive. Respiratory Therapist #1 stated they went to Resident #1's room and assessed Resident #1 for a pulse and there was no palpable pulse, and the resident was not breathing. Respiratory Therapist #1 stated they asked Registered Nurse #1 to call Code 99, chest compressions were initiated, and 911 was called. Respiratory Therapist #1 stated they did not initiate chest compressions; chest compressions were initiated by Registered Nurse #1. Respiratory Therapist #1 stated they do not know how many chest compressions were administered. Respiratory Therapist #1 stated Registered Nurse # 2 came to the room with an Automated External Defibrillator and placed the leads on Resident #1 to initiate shocks.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/18/2025 at 11:43 AM, Registered Nurse #1 stated at 3:38 PM on 02/08/2025, they were called to Resident #1's room by Respiratory Therapist #1. Registered Nurse #1 stated when they went to Resident #1's room they observed Respiratory Therapist #1 performing chest compressions and Respiratory Therapist # 2 providing rescue breaths via an Ambu-Bag to Resident #1. Registered Nurse #1 stated Respiratory Therapist #1 told them Resident #1 was unresponsive and to call code 99 and 911. Registered Nurse #1 stated they asked Security Guard #1 to call code 99, and they called 911 and then went back to Resident #1's room. Registered Nurse #1 stated that Registered Nurse #2 showed up with an Automated External Defibrillator and applied it to Resident #1 and the Automated External Defibrillator announced no shock advised, continue Cardiopulmonary Resuscitation. Registered Nurse #1 stated during chest compressions, Registered Nurse # 2 asked about Resident #1's code status and the Respiratory Therapists were not able to answer. Registered Nurse #1 stated they went back to the nurse's station and verified Resident #1's code status in the Electronic Medical Record, which identified Resident #1 as having an order for Do Not Resuscitate. Registered Nurse #1 stated that they went back to Resident #1's room and informed the staff to stop cardiopulmonary resuscitation. Registered Nurse #1 stated Resident #1's sibling was notified that Resident #1 was unresponsive and that they were sending the resident to the hospital. Registered Nurse #1 stated that when they returned to Resident #1's room, Resident #1 had a pulse, and the Emergency Medical Technicians arrived and took Resident #1 to the hospital. Registered Nurse #1 stated Code 99 was called at 3:38 PM, but they do not know what time Cardiopulmonary Resuscitation ended. Registered Nurse #1 stated the protocol is for two clinicians to verify the resident code status in the Electronic Medical Record before touching the Resident.</p> <p>During an interview on 02/20/2025 at 12:04 PM, Registered Nurse #2 stated they were assigned to respond to Code 99 on 02/08/2025 at 3:38 PM on Five North. Registered Nurse #2 stated they responded to the location with the emergency cart and an Automated External Defibrillator. Registered Nurse #2 stated Resident #1 had in place a pulse oximeter (a device that measures the saturation of oxygen carried in the red blood cells) and a blood pressure cuff, but there was no pulse or blood pressure reading. Registered Nurse #2 stated they applied the Automated External Defibrillator to Resident #1, and it did not advise to give a shock, so cardiopulmonary resuscitation continued. Registered Nurse #2 stated when they first arrived at Resident #1's room, they observed Respiratory Therapist #1 providing rescue breaths via an Ambu-Bag and Registered Nurse #1 performing chest compressions. Registered Nurse #2 stated Respiratory Therapist #2 was not in Resident #1's room when they arrived. Registered Nurse #2 stated they asked if anyone checked on the resident's code status and Registered Nurse #1 left the room to check the code status. Registered Nurse #2 stated Registered Nurse #1 returned to the room and informed them to stop cardiopulmonary resuscitation. Registered Nurse #2 stated Resident #1 was reassessed with a pulse and at the same time the emergency medical service team arrived on the unit.</p> <p>During an interview on 02/21/2025 at 1:30 PM, Respiratory Therapist #3 stated they responded to Code 99 and when they arrived at Resident #1's room, they asked Respiratory Therapist #2 if they needed help and Respiratory Therapist #2 handed them the Ambu-Bag stating they needed to care for another resident and then left the room. Respiratory Therapist #3 stated they provided rescue breaths via the Ambu-Bag to Resident #1 until the Fire Department arrived. Respiratory Therapist #3 stated they do not recall who was performing the chest compressions when they arrived in the room.</p> <p>(continued on next page)</p>		

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