

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Norwich Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 88 Calvary Drive Norwich, NY 13815	

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 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465</p> <p>Based on record review and interviews during the abbreviated survey (NY00361060), the facility failed to establish mechanisms for documenting and communicating the resident's choice regarding Advance Directives to the staff responsible for the resident's care for 1 of 3 residents (Resident #1) reviewed. Specifically, Resident #1 updated their Medical Orders for Life-Sustaining Treatment to reflect a change from wanting cardiopulmonary resuscitation (attempt to restart the heart) to do not resuscitate (allow natural death). The medical record and code status indicators were not revised to reflect the resident's Advance Directives wishes and the facility continued with cardiopulmonary resuscitation orders. Subsequently, when the resident was found without signs of life, the nurse verified the physician order for Full Code status (wishing cardiopulmonary resuscitation) and cardiopulmonary resuscitation was implemented when the resident wished not to be resuscitated. This resulted in no actual harm with likelihood of serious harm, serious injury, serious impairment, or death that is Immediate Jeopardy for all 79 residents in the facility who had advance directives in place.</p> <p>Finding include:</p> <p>The facility policy, Advance Directives, revised ,d+[DATE], documented if a resident did not have a do not resuscitate order upon admission but wanted one, the social worker coordinated completing necessary do not resuscitate paperwork. To ascertain the resident's wishes in an emergency, the resident's Medical Orders for Life Sustaining Treatment and physicians' orders were to be utilized as identifiers of the resident's status. If a resident indicated desire for do not resuscitate, nursing would notify the provider and obtain a written order.</p> <p>Resident #1 had diagnoses including myocardial infarction (heart attack), atherosclerotic heart disease (hardening of the arteries), and surgical aftercare following cardiac surgery. The [DATE] Brief Interview for Mental Status assessment documented the resident's cognition was intact.</p> <p>The [DATE] physician order documented Full Code.</p> <p>The Medical Orders for Life Sustaining Treatment form, signed by the resident on [DATE] at 5:00 PM, documented the resident wished for a do not resuscitate order. The form was witnessed by the Director of Social Services and Registered Nurse #3. The form was signed by Nurse Practitioner #8 on [DATE].</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 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence of a physician order in the resident's electronic medical record for do not resuscitate, and Full Code orders continued.</p> <p>The [DATE] Comprehensive Care Plan documented the resident's Advance Directive were do not resuscitate. Interventions included the Medical Orders for Life Sustaining Treatment were in place.</p> <p>The [DATE] Medical Director progress note documented the resident's long-term prognosis was poor considering underlying multiple medical problems which continually predisposed them to vascular consequence. The note documented to respect the Medical Orders for Life Sustaining Treatment form.</p> <p>The [DATE] at 12:26 PM Registered Nurse Manager #2 progress note documented they spoke with the resident's family member after the resident was found without pulse or respirations and was pronounced deceased by the provider.</p> <p>Written staff statements documented (there was no incident report):</p> <p>- from Assistant Director of Nursing #5, dated [DATE], just before 11:30 AM, an aide (unidentified) reported they needed a nurse immediately in the resident's room. Assistant Director of Nursing #5 and two other registered nurses (unidentified) immediately went to the room and found the resident cyanotic (bluish discoloration of skin from low oxygen), not breathing, and pulse not palpable (unable to be felt). Code status was verified in the electronic medical record and noted Full Code. Cardiopulmonary resuscitation was initiated, a Code Blue was called, as was 911. While gathering the Medical Orders for Life Sustaining Treatment for transport, it was noted the Medical Orders for Life Sustaining Treatment documented the resident wished a do not resuscitate order. Assistant Director of Nursing #5 immediately notified the Administrator. By this time the provider (Physician Assistant #4) had already called the resident's time of death (pronounced the time of death). Assistant Director of Nursing #5 spoke with Registered Nurse #3 via phone regarding witnessing the resident's Medical Orders for Life Sustaining Treatment. Registered Nurse #3 stated they did not verify if the resident's correct code status was reflected in the orders.</p> <p>The undated/unsigned Investigative Summary (later revealed in an interview that Corporate Director of Nursing #12 completed the summary on [DATE]) documented the Medical Orders for Life Sustaining Treatment was not present for the resident upon admission. On [DATE] at 1:32 PM, a telephone order was obtained from Physician Assistant #4 for Full Code. On [DATE] at 5:00 PM the Director of Social Services completed the Medical Orders for Life Sustaining Treatment with the resident reflecting the resident wished for a do not resuscitate order. The Medical Orders for Life Sustaining Treatment was witnessed by Registered Nurse #3. On [DATE], Nurse Practitioner #8 signed the Medical Orders for Life Sustaining Treatment. The resident suffered no adverse effects from administration of cardiopulmonary resuscitation. The resident remained unconscious, did not regain awareness, and was pronounced deceased without experiencing pain or suffering during the intervention.</p> <p>The [DATE] (untimed) Director of Nursing progress note (part of the investigative packet) documented they spoke with Registered Nurse #3 regarding the incident. Registered Nurse #3 acknowledged they co-signed the Medical Orders for Life Sustaining Treatment and failed to verify the physician order in the electronic medical record.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:20 AM, Registered Nurse #3 stated on the day the resident was admitted , they witnessed the resident's Medical Orders for Life Sustaining Treatment. They did not add the physician order for do not resuscitate because they assumed the resident's admission nurse would do that as part of the admission assessment. They stated they did not report to the resident's admission nurse they had co-signed the Medical Orders for Life Sustaining Treatment or that they did not complete the physician order. If the physician order did not match the Medical Orders for Life Sustaining Treatment, then staff could start cardiopulmonary resuscitation on a resident that wished do not resuscitate, or they might not start cardiopulmonary resuscitation on someone that wished Full Code causing harm.</p> <p>During an interview on [DATE] at 11:48 AM, the Director of Nursing stated after the nurse witnessed the Medical Orders for Life-Sustaining Treatment, the nurse was responsible to check that the physician order matched.</p> <p>During an interview on [DATE] at 1:31 PM, the Medical Director stated the physician order should be obtained and entered in the electronic medical record right away after the Medical Orders for Life-Sustaining Treatment was witnessed.</p> <p>During an interview on [DATE] at 4:50PM, the Administrator stated if the resident wished to change their code status, they expected the nurse who witnessed the Medical Orders for Life Sustaining Treatment to immediately update the code status in the electronic medical record.</p> <p>-----</p> <p>The facility was notified of the Immediate Jeopardy on [DATE] at 5:38 PM.</p> <p>Immediate Jeopardy was removed on [DATE] at 1:47 PM prior to survey exit based on the following corrective actions taken:</p> <ul style="list-style-type: none"> - 100% of staff on duty were educated according to the approved training plan. - All staff identified for education received education on [DATE] and [DATE]. The staff that did not receive education will complete education upon their return, prior to the start of their shift. - Interviews were completed on [DATE] to determine compliance with staff training and education including 3 licensed practical nurses, 3 registered nurses and 2 certified nurse aides. Staff confirmed participation and understanding of the education. <p>10NYCRR 400.21(c)</p>		