STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335859	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Village at Endwell	14 Village Drive Endwell, NY 13760

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the recertification survey conducted 11/19/2025-11/20/2025, the facility did not verify the presence of advance directives or the resident's wishes regarding cardio-pulmonary resuscitation, upon readmission, for one (1) of three (3) residents (Resident #21) reviewed. Specifically, during a hospitalization Resident #21 changed their advance directives to include cardio-pulmonary resuscitation should they be found without a pulse, their readmission orders did not reflect their preference and there was a do not resuscitate (allow natural death) order in place for two (2) days after readmission. Findings include: The undated facility policy EMOLST (Electronic Medical Orders for Life-Sustaining Treatment)/Advanced Directives, retrieved 11/2025, documented residents had the right to direct their own medical treatment, including withholding or withdrawing life sustaining treatment and their wishes were documented in their electronic medical record. Hospital advance directives were to be confirmed at admission, by the social worker or nurse, as they were a continuation of hospital orders. A licensed provider was to review and sign the Medical Orders for Life-Sustaining Treatment and physician orders after conferring with the resident.The undated facility form admission Checklist documented the nurse was to enter admission orders and advance directives into the resident's medical record.Resident #21 had diagnoses including depression, stroke, and anxiety. The 10/13/2025 annual Minimum Data Set assessment documented the resident had intact cognition.Electronic Medical Orders for Life-Sustaining Treatment dated 8/18/2023 and last reviewed by Physician #5 on 9/19/2025, documented the resident's wish for resuscitation orders was do not resuscitate and the resident had medical decision-making capacity. The resident verbally consented for resuscitation orders. The 10/23/2025 revised comprehensive care plan documented the resident had advanced orders. Interventions included see physician orders and review advanced directives quarterly and as needed.The 11/13/2025 Nurse Practitioner #4 progress note documented the resident stated they had sudden increased left-sided weakness. The resident was to be sent to the hospital for evaluation and was do not resuscitate status.The resident was hospitalized from [DATE]-[DATE]. The 11/13/2025 at 4:02 PM Electronic Medical Orders for Life-Sustaining Treatment completed during hospitalization, documented the resident verbally consented to cardio-pulmonary resuscitation with a trial of intubation and no limitation on medical interventions. The resident gave informed consent and had medical decision-making capacity. The hospital physician documented the previous form was voided and a new form was completed. The 11/17/2025 at 11:25 AM hospital discharge summary documented the resident was a full code (perform cardio-pulmonary resuscitation) when discharged .The 11/17/2025 at 3:47 Director of Nursing readmission Observations evaluation documented the resident was awake and responding appropriately. The resident was oriented to person, place, time, and situation.The 11/17/2025, 11/18/2025, and 11/19/2025 Kardex (care instructions) did not document an advance directives statusThe 11/18/2025 at 1:44 PM, Physician #5 resident admission history and physical assessment documented the resident was readmitted from the hospital and was seen and examined in their room. The resident was alert and oriented to self, time, and had difficulty remembering the name of the (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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. The resident's advance directive status was do not resuscitate.During an interview on 11/19/2025 at 12:42 PM, Resident #21 stated they wanted cardio-pulmonary resuscitation performed if their heart stopped.The 11/19/2025 at 1:09 PM Physician #5 order, entered into the medical record by the Director of Nursing, documented Full Code advance directives and the do not resuscitate order was discontinued.The 11/19/2025 at 1:31 PM Resident #21's electronic medical record documented the advance directives code status was changed to cardio-pulmonary resuscitation.During an interview on 11/20/2025 at 9:41 AM, Licensed Practical Nurse Manager #3 stated when a resident was admitted or readmitted , the Unit Manager or supervisor took the admission/readmission paperwork and reviewed the discharge summary and paperwork with the provider. The nurse went over the orders with the provider and entered the orders into the medical record. The Medical Orders for Life-Sustaining Treatment was reviewed with the resident by the provider, social worker, or nurse. The physician signed off on it and the nurse entered the order in the medical record. Staff had easy access to orders and the status was flagged in the record's banner to determine a resident's code status in the event the resident was unresponsive. During an interview on 11/20/2025 at 9:54 AM, the Director of Nursing stated they looked at the resident's Medical Orders for Life-Sustaining Treatment when the resident returned from the hospital and noted it was changed when they were at the hospital. They stated the day the resident returned, the facility had other residents also returning and they forgot to put the new physician order in for cardio-pulmonary resuscitation. They stated they had it on their to-do list and did not get to it until 11/19/2025. The procedure for readmission was that the facility received report from the hospital, received the hospital packet, reviewed the packet information (to include the discharge summary and after visit summary and Electronic Medical Orders for Life-Sustaining Treatment, and review the Medical Orders for Life-Sustaining Treatment with the resident to ensure that was their wishes. The provider was called, and orders were reviewed with them. Any nurse was able to enter physician orders into a resident's medical record and the Director did not think to ask another nurse to do so.During an interview on 11/20/2025 at 12:00 PM, Physician #5 stated they saw the resident on 11/18/2025 and asked the resident what their advance directive wishes were. The resident informed the physician they wished to remain do not resuscitate, and therefore the physician did not change the order. The physician stated they were not made aware by facility staff the Medical Orders for Life-Sustaining Treatment were changed in the hospital. They stated they did not think to check the Medical Orders for Life-Sustaining Treatment as the resident had not informed them they wanted to have cardio-pulmonary resuscitation performed.During an interview on 11/20/2025 at 12:15 PM, the Administrator stated they expected readmission/admission orders and Medical Orders for Life-Sustaining Treatment be reviewed, were accurate and done in a timely manner. Physician orders should be entered in the resident's record within one hour for one admission and within the first four hours post admission if multiple admissions were done that shift. A Medical Orders for Life-Sustaining Treatment order changed two days post admission was not timely. If the physician orders were not the same as the Medical Orders for Life-Sustaining Treatment, life saving measures may not be what the resident's actual wishes were. 415.3(e)(2)(iii)