STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396101	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab at Shannondell	5000 Shannondell Drive Audubon, PA 19403

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 - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff interviews, review of faciltiy policy and review of clinical records, it was determined that the facility failed to inform the resident and/or her responsible party of their right to formulate an advanced directive upon admission, and failed to clarify the resident's code status upon admission to ensure that the resident's wishes regarding end of life care would be honored for 1 out of 2 residents reviewed (Resident R1). Findings include: Review of the facility policy, Patient Code Status, with a revision date of [DATE], indicted that the purpose of the policy was to ensure that patients are able to choose their code status and to ensure that all necessary documentation is included in patient's chart. The policy also indicated that social services will verify the patient's code status choice (DNR or Full Code) with their admission assessment within 1 business day of a resident's admission. Continued review of the policy indicated that a physician's order for DNR will be contained in the electronic medical record, and that if a patient is not DNR, the patient is considered to be Full Code, and that if a patient is unable to express these wishes, the social services department will consult with the appropriate decision makers for the resident as part of their admission assessment. Review of the resident's hospital discharge summary indicated that the resident was admitted into the hospital's intensive care unit on [DATE] after a fall in her home, and subsequently transferred to the facility for rehabilitation services on [DATE]. Review of a nursing notes dated [DATE] at 2:00 p.m. by the licensed nurse (Employee E3) who completed the resident's nursing admission assesssment indicated that the resident was admitted into the facility on the referenced date with diagnoses of fall, traumatic, subdural hematoma (bleeding in the brain that can happen after a head injury; subarachnoid hemorrhage (a type of stroke); intraparenchymal Hematoma (a type of stroke that occurs when blood accumulates in the brain tissues), intraventricular Hemorrhage (a type of bleeding that occurs within the ventricles of the brain, which are fluid-filled spaces that help cushion and protect the brain). Continued review of the resident's nursing note indicated that the resident was assessed by Employee E3 as being Alert and Oriented x 2 (a term used in healthcare to describe a patient's mental status, and indicates that the person may be aware of their own identity and current time, but may not be oriented to place or situation). (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of information received by State Survey Agency on [DATE] reported that the resident had a fall on [DATE], and subsequently passed away on the same day. Review of documentation provided by the facility, and completed by the charge nurse who was assigned to Resident R1 on [DATE] from 7:00 a.m. through 7:00 p.m., indicated that the resident had a fall on [DATE]. Review of the documentation indicated that the resident's nurse aide found her on the floor lying on her back in front of the recliner chair where she was last seen sitting. The documentation indicated that the nurse aide alerted Licensed nurse, Employee E4 of the incident, was assesssed by Employee E4 and placed back on bed. Facility documentation reviewed on the event indicated that when assessed after the fall, the resident was awake and conscious, but unable to follow verbal commands, or tell the staff what happened. Continued review of the resident's fall incident documentation also indicated that the nurse practitioner was notified of the fall, and ordered that the resident to be sent out to the emergency room . The resident's husband was also contacted and notified of her fall and the nurse practitioner's order to send the resident out to the hospital Continued review of the documentation provided on the incident revealed that while completing addition assessments on the resident (neurological checks), the resident's blood oxygen level (the amount of blood that an individual has circulating in their blood) began to decrease into the 80's (a blood oxygen level that would require immediate medical attention), and a pulse could not be read for the resident when attempts were made to obtain one. Facility documentation indicated that cardiopulmonary resuscitation (CPR-an emergency life saving procedure when an individual's heart stops breathing) was started at 4:30 p.m. Documentation also indicated that emergency medical technicians arrived and called the resident's son to obtain the resident's code status, and that the son verbalized to the emergency medical technicians that he wanted CPR to continue on his mother. Continued review of he documentation on the incident revealed that CPR continued for 40 minutes, and that the resident was pronounced as deceased at 5:08 p.m. Review of information from the hospital indicated that on [DATE] (date of the resident's hospital admission), the physician reviewed that resident's code status and indicated Code status goals of care discussed: full code. Review of hospital documentation sent over to the facility with the resident's hospital discharge summary by the hospital was a form with Physician Care Manager document that indicated that the resident's code status was DO NOT RESUSITATE/DO NOT INTUBATE (a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest), in addition to information related to the resident's discharge orders, follow up appointments, and the resident's prescriptions. Review of the resident's clinical record at the facility did not show evidence that upon the resident's admission on [DATE] at approximately 2:00 p.m. that any attempt was made by the facility to determine from the resident and/or her family/responsible party, if the resident had an advanced directive or wanted to develop an advanced directive if she did not have one. Continued review of the clinical record also did not show evidence that upon admission the facility made any attempts to obtain the resident's code status (the level of medical interventions a person wishes to have started if their heart or breathing stops) to ensure that the resident and/or her responsible party's request regarding this decision would be honored by the facility, and that staff would know how to correctly proceed in a medical event involving the resident. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Employee E4 (licensed nurse) on [DATE] at 12:30 p.m. Employee E4' statement was reviewed and confirmed regarding her account of the incident on [DATE]. Employee E4 reported that the resident was Full Code when a resident is admitted on the weekend. It was verified with her that Resident R1 was admitted on a Friday at or before 2:00 p.m. Employee E4 reported that when the EMT arrived at the facility, they saw where the resident was a DNR, so an EMT called the resident's son and asked if he wanted EMT to continue providing CPR to the resident. During an interview with Employee E3 (licensed nurse) on [DATE] at 1:04 p.m. the nurse reported that the resident came in at approximately 2:00 p.m. and that the resident's family came on [DATE], but after he completed the resident's admission. Employee E3 reported that he obtained the medical report from the sending hospital which included information on her history and physical. Employee E3 reported that there was no information discussed about the resident's code status, and that obtaining the resident's code status is part of the social services assessment. During an interview with Employee E5 (licensed nurse/case manager supervisor to the social workers) Employee E5 reported that she was notified of the incident regarding Resident R1 and assisted staff with providing CPR to the resident. Employee E5 reported that when the EMT'S arrived, one EMT called the resident' son to confirm the resident's code status, and the son instructed the EMT that he can continue CPR on his mother. Employee E5 reported that she remained in the room with the EMT'S, who eventually pronounced the resident dead. Continued interview with Employee E5 confirmed that by default she (Resident R1) was a Full Code when she was admitted into the facility. Employee E5 reported that social workers see new admissions within the next business day after a resident is admitted to confirm the resident's code status, and to complete the social services admission assessment. Employee E5 reported that if the resident is not awake, alert or oriented, the social worker will contact the family for the admission assessment and the code status information. The facility failed to inform Resident R1 and/or her responsible party of their right to formulate an advanced directive, upon admission, and failed to clarify Resident R1's code status upon admission to ensure that the resident's wishes regarding end of life care would be honored. 28 Pa. Code 201.29 (a) Resident Rights