STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON ST RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=J	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, family and physician interviews, the facility failed to honor 1 (Resident #1) of 3 resident 's desires for code status who expired in the facility. The Immediate Jeopardy began on 10/21/13. The administrator was notified of the Immediate Jeopardy on 11/05/2013 at 6:20 pm. The Immediate Jeopardy was removed on 11/7/13 at 7:15 pm when the facility provided an acceptable Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. The findings included: Resident #1 was admitted to the facility on October 15, 2013 with medical diagnoses which included sepsis and left abdominal abscess deemed inoperable. Her medical condition was diagnosed as terminal and guarded with a recommendation for hospice consultation. The	F 242	Preparation and submission of the plan of correction is in response to DHHS 2567 for the survey and does not constitute an agreement or admission by Autumn Care of Raeford of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Autumn Care of Raeford contends that it was in substantial compliance with the requirements 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, Autumn Care of Raeford submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of 11/11/2013. **For the resident affected:** Resident # 1 was admitted to facility on 10/15/2013 and on 10/16/2013 the attending physician wrote an order for resident to be a DNR. Resident # 1 also admitted with a signed and notarized Advanced Directive for a Natural Death ("Living Will") which was initialed by Resident #1 to "withhold or withdraw life-prolonging measures". Item #6 of the Advanced Directive states "If I have an Available Health Care Agent: If I have appointed a health care agent by executing a health care power of attorney or similar	11/11/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Danielle Mattia	Administrator	12/2/13

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.

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F 242	Continued From page 1 resident had a living will dated October 7, 2013 which indicated to "withhold or withdraw life prolonging measures." Section one (I) was not completed which indicated under which circumstances life prolonging measures were to be withheld. Item #6 of the Advanced Directive stated "If I have an Available Health Care Agent: If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that: Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life." The most recent Minimum Data Set (MDS) dated 10/20/13 indicated Resident #1 was cognitively intact, Brief Interview for Mental Status (BIMS) score 15. A review of Resident 's #1 care plan with effective date from October 15, 2013 to October 21, 2013 indicated "Advance Directive Needs: Code Status: DNR (Do Not Resuscitate)." A review of a physician order was written for Do Not Resuscitate (DNR) dated 10/16/13. During a phone interview on 11/6/2013 at 8:40 am, the family member stated she had received a phone call from the nurse the week prior to the resident passing away and informed of the order to change the resident code status to full code. During a phone interview on 11/7/13 at 2:05 pm, the family member stated she received a call on the afternoon of the 18th by the nurse that stated she made rounds with the doctor. The family member further stated she came in to the facility	F 242	instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that: Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life. Advanced Directive was dated and notarized 10/07/13. Resident expired in facility on 10/21/13. **For residents with the potential to be affected:** An audit of all residents was started on 10/22/2013 and completed on 10/25/2013 by Social Worker, Medical Records Clerk and Assistant Director of Nursing to validate that the most current physician order was in agreement with the Electronic Health Record as well as the code status books maintained at each nurses station. After the audit was completed, it was discovered that this was an isolated event due to no other affected areas. An audit was completed on 11-05-13 by the ADON to ensure that all residents who had been admitted from 10-25-13 through 11-05-13 had physician orders in agreement with the Electronic Health Record as well as the code status books maintained at each nurses station. No other areas were identified. **Measures put in place:** In-service training began the morning of 11/06/2013 and completed on 11/11/2013 by Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator for licensed nurses and the Social Worker regarding Resident Rights as it relates to honoring wishes of alert and oriented residents. Any alert and oriented resident	

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F 242	Continued From page 2 at approximately 6:40 pm and spoke with Nurse # 3 and told her that she was going to go and talk with Resident #1 about her decision for full code. The family member stated the resident confirmed with her that she wanted to be a full code at the time of the visit. She stated this was the last conversation she had with the resident or facility staff about the resident ' s advance directives. The family member stated the resident had been doing better medically since being at the facility and that she just wasn ' t ready to give up. A review of the facility Progress Note by the attending physician dated 10/18/13 revealed " Resident alert and oriented x 3. Pt request full code. " A review of a facility Physician Order Sheet dated 10/18/13 signed by the attending physician revealed "Pt request to be a full code." On 11/5/13 at 9:50 am, during an interview, Nurse #3 stated Resident #1 refused the hospital 's recommendation for hospice and wanted to be a full code. She further stated she was with the doctor when he made rounds and visited with the resident on October 18, 2013 and the resident told the doctor she wanted to be a full code. Nurse #3 further indicated it was late on Friday afternoon on the 18th so it was on Monday October the 21st when she gave the social worker a copy of the order to get the family to sign the new order. Nurse #3 further indicated she was not familiar with the type of power of attorney the family member had for Resident #1. She further stated "All I know is that I was told by my supervisor, the ADON (Assistant Director of Nursing) that I could not take the order off until the family member gave permission because she	F 242	who expresses a desire to change any aspect of their Advance Directive will be honored according to resident wishes. In the event a resident is unable to make decisions for themselves, the expressed wishes of the responsible party and/or POA then become effective and those wishes are honored. Once resident and/or POA/Patient Representative has conveyed wishes, licensed nurse will contact the attending physician for appropriate order. The nurse then writes the telephone order, transcribes the order into the Electronic Health Record and places a copy of the telephone order in to the code status notebook on the unit to replace the previous status sheet. The hand written order is then placed into the physician's folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. This facility will continue to provide resident rights education during orientation for new employees and at least annually on-going. A new code status communication form was implemented on 11-05-2013 specifically for the Social Worker to utilize in the event the resident expresses wishes other than the current status order. Social Worker received in-service on 11-05-13 by Administrator to ensure the wishes of the resident are conveyed to the appropriate licensed nurse. Licensed nurses were in-serviced on the new communication form and on the importance of contacting the physician immediately once alerted that resident has requested a change in code status on 11-07-13 and completed on 11-11-2013 by the Director of Nursing, Assistant	

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F 242	Continued From page 3 was her power of attorney." On 11/7/13 at 2:19 pm, Nurse # 3 stated she recalled talking to the resident 's hcpoa on the phone and after she came in to the facility around 6:40 pm on October 18, 2013 regarding the new doctor 's order for full code status for Resident #1. Nurse #3 further stated the resident ' s hcpoa did tell her that she was going to discuss with the resident her decision for full code status after she arrived in the building on the evening of October 18, 2013. She further indicated she did not speak to the hcpoa after the hcpoa visited with the resident because she had already left for the day. During an interview on 11/5/13 at 11:10 am, the Social Worker stated she did not accept the order from the nurse because there was nothing to get permission from the family for. The social worker further indicated Resident #1 was alert and oriented and could make her own decisions about her directives. She stated she told the nurse she would go in and speak with the resident because the resident told her she wanted to be a DNR when she completed her assessment with her. The Social Worker further indicated she did go in and speak with the resident on the afternoon of October 18, 2013 prior to leaving work around 5 pm. She further stated the resident informed her she wanted to be a DNR when she went to see her before leaving work on the same date. The Social Worker stated she did not go back to the nurse and let her know that the resident told her she wanted to be a DNR after the discussion of the order for full code. The Social worker further stated she did not see the nurse again before she left the building. She further stated she did not tell the nurse on Monday the 21st of October of the resident ' s conversation with her about DNR after	F 242	Director of Nursing and the Staff Development Coordinator. Beginning 10-22-13 and completed on 11-11-13, the Social Worker, Dietary Manager, Medical Records Clerk and Care Plan Coordinators began interviewing alert and oriented residents and contacting the POA/Responsible Party of the residents who are unable to make decisions to verify that their wishes are in agreement with the current code status in the Electronic Health Record. **Monitoring/QA:** Two random interviews will be performed by the Director of Nursing with licensed nursing staff per week x 4 weeks, then two interviews monthly x 6 months to in ensure licensed staff can demonstrate knowledge of resident rights as it relates to resident wishes with Advance Directives. Director of Nursing, Assistant Director of Nursing, or designee will continue to audit every admission for code status within 24 hours of admission continuously. The facility will continue to determine resident's desires and wishes upon admission related to code status by the Admission Coordinator. The Admission Coordinator will continue to communicate this information to Medical Records and the licensed nurse in order to review the resident's code status with the physician in order to obtain a physician's order for the appropriate order for code status. Once resident and/or POA has conveyed wishes, licensed nurse will contact the attending physician immediately for appropriate order, according to Autumn policy. Autumn's Policy states that: Once a	

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F 242	Continued From page 4 the discussion of the doctor ' s order for full code. The social worker further indicated it was the responsibility of the nursing staff to key in the order for the code status change into the computer system. The Social Worker stated she confirm the code status orders in the computers quarterly. Review of the nurse's note dated 10/21/13 at 6:31 pm by Nurse #1 revealed "writer into resident ' s room and unable to arouse resident, sternal rub and stimuli uneventful. 100 hall nurse assisted writer and still no arousal. No heartbeat or pulse felt. Resident is a DNR. Call placed to MD (medical doctor). RP (responsible party) made aware and stated "I will be there in a few minutes. Awaiting her arrival. (6:20 pm)." On 11/5/13 at 8:55 am, in an interview with Nurse #1 revealed she found Resident #1 unresponsive on October 21, 2013 at approximately 6 pm. She stated she walked by Resident #1's room and noticed she had not touched her dinner tray which was unusual for the resident. Nurse #1 stated Resident #1 was without pulse or heartbeat and her body was warm. She further indicated the resident 's eyes were dilated. She stated she was unable to arouse Resident #1 by firmly rubbing on the resident 's chest so she went to get Nurse #2 to verify with her because the resident was a DNR. . Nurse #1 stated she checked the code status book on the floor and it contained the DNR order for Resident #1. On 11/5/13 at 12:02 pm, during a phone interview with the attending physician, he stated he expected the nursing staff to carry out the order as written. The physician stated he wrote the order because the resident was alert and oriented	F 242	resident and/or POA/Patient Representative has conveyed wishes, licensed nurse will contact the attending physician for appropriate order. The nurse then writes the telephone order, transcribes the order into the Electronic Health Record and places a copy of the telephone order in to the code status notebook on the unit to replace the previous status sheet. The hand written order is then placed into the physician's folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. In the event an alert and oriented resident expresses a desire to change code status, or the POA of a resident who is unable to make decisions expresses the desire to change code status, the social worker will notify a licensed nurse immediately via the Code Status Communication Form. The social worker then documents that she has verified the resident's or POA/Responsible party's wishes for code status. During the morning clinical meeting (Monday through Friday), consisting of Director of Nursing, Assistant Director of Nursing, Administrator, Care Plan Coordinators, Rehab Manager and Social Worker in attendance, Care Plan Coordinator will notify the social worker of the residents who are in their 7 day assessment window. The social worker will then take that list of residents and verify code status with resident, POA or Responsible party (whichever applicable) as it relates to patient wishes. The social worker will then verify code status with resident,	

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F 242	Continued From page 5 and requested it. He further stated because the resident and family made one decision at the hospital did not mean they could not change their minds about their directives later. The physician further indicated his plan was for the staff to contact the family member who was the health care power of attorney (hcpoa) to make sure she was aware of the resident 's decision for full code to ensure everyone was on the same page. In an interview on 11/5/13 at 12:13 pm, the Director of Nursing (DON) indicated the facility Physician Order Sheet is an order and under no circumstances should the nurse not have carried the order out given by the doctor. The DON further indicated she expected the nurse to process the order for the code status change into the computer, discontinue the DNR order and put in the full code order. The DON further indicated the nurse should have notified the physician that gave the order immediately if for any reason she was unable to carry out the doctor 's order. She further indicated the nurses are expected to verify the resident ' s code status via the quickest resource whether it is the computer or the code status book at the nurse 's station. On 11/5/13 at 3:48 pm, during an interview, the Assistant Director of Nursing (ADON) stated she was not aware of the order for full code for Resident #1 until after the resident had passed away. The ADON stated Nurse #3 came to her with the order the day after the resident had passed away. She stated she immediately called the administrator and the DON who was out of the building and informed them. The ADON stated she did not give instructions to Nurse #3 not to transcribe the order for code status change.	F 242	POA or Responsible party (whichever applicable) as it relates to patient wishes. Social worker will also document this conversation in the Electronic Health Record immediately. The Care Plan Coordinator will compare that the Social Workers documentation is in agreement with the current physicians order. Audits will then be done by the Care Plan Coordinator on 5 residents a month x 4 months and then 10 residents quarterly on-going. An audit of all residents who have expired in the facility since 10/22/2013 will be performed beginning 11-07-2013 by the Medical Records Clerk to confirm the code status was followed on-going. Any area of identified concern will be addressed immediately and will be addressed in Quality Assurance meetings for further action plans during morning meetings.	

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F 242	Continued From page 6 The facility provided the following Credible Allegation on November 7, 2013 at 7:15 pm. Credible Allegation of Compliance: F-Tag 242 For the Provision of Care to Maintain the highest level of function for residents. The area of concern identified during staff interviews revealed staff are unfamiliar with resident rights as it relates to resident wishes per state surveyor on 11/06/2013. Resident # 1 was admitted to facility on 10/15/2013 and on 10/16/2013 the attending physician wrote an order for resident to be a DNR. Resident # 1 also admitted with a signed and notarized Advanced Directive for a Natural Death (" Living Will ") which was initialed by Resident #1 to " withhold or withdraw life-prolonging measures " . Item #6 of the Advanced Directive states " If I have an Available Health Care Agent: If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that: Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life. Advanced Directive was dated and notarized 10/07/13. The discrepancy regarding F-Tag 242 was that a nurse was not aware that a Health Care Power of Attorney does not become effective and cannot make decisions for the resident until that resident is unable to make decision for self.	F 242		

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F 242	Continued From page 7 In-service training began the morning of 11/06/2013 by Director of Nursing for licensed nurses and the Social Worker on Resident Rights as it relates to honoring wishes of alert and oriented residents. Any alert and oriented resident who expresses a desire to change any aspect of their Advance Directive will be honored according to resident wishes. In the event a resident is unable to make decisions for themselves, the expressed wishes of the responsible party and/or POA then become effective and those wishes are honored. Once resident and/or POA/Patient Representative has conveyed wishes, licensed nurse will contact the attending physician for appropriate order. The nurse then writes the telephone order, transcribes the order into the Electronic Health Record and places a copy of the telephone order in to the code status notebook on the unit to replace the previous status sheet. The hand written order is then placed into the physician ' s folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. Licensed nurses will continue to be in-serviced prior to beginning of next tour of scheduled duty. This facility will continue to provide resident rights education during orientation for new employees and at least annually on-going. A new code status communication form was implemented on 11-05-2013 specifically for the Social Worker to utilize in the event the resident expresses wishes other than the current status order. Social Worker received in-service on 11-05-13 by Administrator to ensure the wishes of the resident are conveyed to the appropriate licensed nurse. Licensed nurses were in-serviced on the new	F 242		

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F 242	Continued From page 8 communication form and on the importance of contacting the physician immediately once alerted that resident has requested a change in code status on 11-07-13. Beginning 10-22-13, the Social Worker or designee began interviewing alert and oriented residents and contacting the POA/Responsible Party of the residents who are unable to make decisions to verify that their wishes are in agreement with the current code status in the Electronic Health Record. Two random interviews will be performed with licensed nursing staff per week x 4 weeks, then two interviews monthly x 6 months to in ensure licensed staff can demonstrate knowledge of resident rights as it relates to resident wishes with Advance Directives. DON, ADON or designee will continue to audit every admission for code status within 24 hours of admission continuously. The facility will continue to determine resident ' s desires and wishes upon admission related to code status by the Admission Coordinator. The Admission Coordinator will continue to communicate this information to Medical Records and the licensed nurse in order to review the resident ' s code status with the physician in order to obtain a physician ' s order for the appropriate order for code status. Once resident and/or POA has conveyed wishes, licensed nurse will contact the attending physician immediately for appropriate order, according to Autumn policy. Autumn ' s Policy states that: Once a resident and/or POA/Patient Representative has conveyed wishes, licensed nurse will contact the attending physician for appropriate order. The nurse then	F 242		

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F 242	Continued From page 9	F 242		

writes the telephone order, transcribes the order into the Electronic Health Record and places a copy of the telephone order in to the code status notebook on the unit to replace the previous status sheet. The hand written order is then placed into the physician ' s folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record.

In the event an alert and oriented resident expresses a desire to change code status, or the POA of a resident who is unable to make decisions expresses the desire to change code status, the social worker will notify a licensed nurse immediately via the Code Status Communication Form. The social worker then documents that she has verified the resident ' s or POA/Responsible party ' s wishes for code status. During the morning clinical meeting (Monday through Friday), with DON, ADON, Administrator, MDS nurses, Rehab Manager and Social Worker in attendance, MDS nurse will notify the social worker of the residents who are due for assessment on that day. The social worker will then take that list of residents and verify code status with resident, POA or Responsible party (whichever applicable) as it relates to patient wishes. On Fridays, MDS nurse will alert the social worker of the residents who are due for assessment that day as well as the residents who are due for an assessment for the coming weekend. The social worker will then verify code status with resident, POA or Responsible party (whichever applicable) as it relates to patient wishes. Social worker will also document this conversation in the Electronic Health Record immediately. The MDS Nurse will compare that

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F 242	Continued From page 10 the Social Workers documentation is in agreement with the current physicians order. On 11/7/2013 at 7:15 pm, verification of the credible allegation was evidenced by interviews of licensed nursing staff and the social worker related to resident 's rights. The licensed nursing staff and the social worker verbalized understanding of the need to notify the physician immediately if a resident request a code status change. Staff also verbalized understanding of resident 's rights.	F 242		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff, family and physician interviews, the facility failed to activate the Emergency Medical Services system via 911 and provide Cardiopulmonary Resuscitation (CPR) per doctor 's order for 1 of 3 residents (Resident #1) that expired in the facility. The Immediate Jeopardy began on 10/21/13. The administrator was notified of the Immediate Jeopardy on 11/05/2013 at 6:20 pm. The Immediate Jeopardy was removed on 11/7/13 at 7:15 pm when the facility provided an acceptable	F 309	**For the resident affected:** Resident # 1 was admitted to facility on 10/15/2013 and on 10/16/2013 the attending physician wrote an order for resident to be a DNR. Resident # 1 also admitted with a signed and notarized Advanced Directive for a Natural Death ("Living Will") which was initialed by Resident #1 to "withhold or withdraw life-prolonging measures". Item #6 of the Advanced Directive states "If I have an Available Health Care Agent: If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that: Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life. Advanced Directive was dated and notarized 10/07/13. The social worker documented the "status is DNR" in her note	**11/11/2013**

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F 309	Continued From page 11 Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Review of the facility 's CPR policy dated 10/1/2006 revealed "the facility recognizes the fundamental rights of an individual to control the decisions related to his or her medical care. It is the policy of this facility to communicate our CPR policy to all patients and/or their responsible party prior to admission and to ensure to the extent possible that a patient 's wishes regarding resuscitation and life sustaining treatment are honored. In the event a patient has expressed a desire to be a full code, and is found to be in cardiopulmonary arrest, licensed nursing staff will initiate basic life support and 911 emergency services will be called for transport to local hospital for further life support. All licensed nurses are CPR certified and will be recertified on an annual basis either through American Heart Association or American Red Cross. The findings included: Resident #1 was admitted to the facility on October 15, 2013 with medical diagnoses which included sepsis and left abdominal abscess deemed inoperable. Her medical condition was diagnosed as terminal and guarded with a recommendation for hospice consultation. The	F 309	that was written on 10-21-2013 at 15:40. The resident was found to be unresponsive by licensed nurse on 10-21-13 at 18:00. The nurse documented at 18:31 that there was no pulse or heart beat and that the code status was DNR. **For residents with the potential to be affected:** An audit of all residents was started on 10/22/2013 and completed on 10/25/2013 by Social Worker, Medical Records Clerk and Assistant Director of Nursing to validate that the most current physician order was in agreement with the Electronic Health Record as well as the code status books maintained at each nurses station. After the audit was completed, it was discovered that this was an isolated event due to no other affected areas. An audit was completed on 11-05-13 by the Assistant Director of Nursing to ensure that all residents who had been admitted from 10-25-13 through 11-05-13 had physician orders in agreement with the Electronic Health Record as well as the code status books maintained at each nurses station. No other areas were identified. Educational In-Service was provided by Assistant Director of Nursing prior to beginning audit to Medical Records Clerk and Social Services on 10/22/2013. The in-service educated the Medical Records Clerk and the Social Worker on how to validate physicians order, code status in Electronic Health Record and Code Status Book on each nursing unit. **Measures put in place:** A new code status communication form was	

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F 309	Continued From page 12 resident had a living will signed October 7, 2013 which indicated to "withhold or withdraw life prolonging measures." Section one (I) was not completed which indicated under which circumstances life prolonging measures were to be withheld. Item #6 of the Advanced Directive states "If I have an Available Health Care Agent: If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that: Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life." The most recent Minimum Data Set (MDS) dated 10/20/13 indicated Resident #1 was cognitively intact, Brief Interview for Mental Status (BIMS) score 15. A review of Resident 's #1 care plan with effective date from October 15, 2013 to October 21, 2013 indicated "Advance Directive Needs: Code Status: DNR (Do Not Resuscitate)." A review of a signed physician order was written for Do Not Resuscitate (DNR) on 10/16/13. During a phone interview on 11/6/2013 at 8:40 am, the family member stated she received a phone call from the nurse the week prior to the resident passing away and was informed of the order to change the resident code status to full code. During a phone interview on 11/7/13 at 2:05 pm, the family member stated she received a call on the afternoon of the 18th by the nurse that stated she made rounds with the doctor. The family member further stated she came in to the	F 309	implemented on 11-05-2013 specifically for the Social Worker to utilize in the event the resident expresses wishes other than the current status order. Social Worker received in-service on 11-05-13 by Administrator to ensure the wishes of the resident are conveyed to appropriate staff. Licensed nurses were in-serviced on the communication form by Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator starting on 11-06-13 and completed on 11-11-2013. Licensed nurses received in-service training beginning on 11-05-13 and completed on 11-11-2013 on receiving physician orders and transcription of physician orders and validating that most current physician's order is in agreement with documents in place according to wishes for code status and physician's order. Director of Nursing, Assistant Director of Nursing or designee will continue to audit every admission for code status within 24 hours of admission continuously. The facility will continue to determine resident's desires and wishes upon admission related to code status by the Admission Coordinator. The Admission Coordinator will continue to communicate this information to Medical Records and the licensed nurse in order to review the resident's code status with the physician in order to obtain a physician's order for the appropriate order for code status according to Autumn Policy. Once resident and/or POA has conveyed wishes, licensed nurse will call the attending physician for appropriate order. The nurse then writes the telephone order, transcribes the order into the Electronic Health Record	

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F 309	Continued From page 13 facility at approximately 6:40 pm and spoke with Nurse # 3 and told her that she was going to go and talk with Resident #1 about her decision for full code. The family member stated the resident confirmed with her that she wanted to be a full code at the time of the visit. She stated this was the last conversation she had with the resident or facility staff about the resident ' s advance directives. The family member stated the resident had been doing better medically since being at the facility and that she just wasn 't ready to give up. A review of the facility Progress Note by the attending physician dated 10/18/13 revealed "Resident alert and oriented x 3. Pt request full code." A review of a facility Physician Order Sheet dated 10/18/2013 signed by the attending physician revealed "Pt request to be a full code." On 11/5/13 at 9:50 am, during an interview, Nurse #3 stated Resident #1 refused the hospital 's recommendation for hospice and wanted to be a full code. She further stated she was with the doctor when he made rounds and visited with the resident on October 18, 2013 and the resident told the doctor she wanted to be a full code. Nurse #3 further indicated it was late on Friday afternoon on the 18th so it was on Monday October the 21st when she gave the social worker a copy of the order to get the family to sign the new order. Nurse #3 further indicated she was not familiar with the type of power of attorney the family member had for Resident #1. She further stated " All I know is that I was told by my supervisor, the ADON (Assistant Director of Nursing) that I could not take the order off until	F 309	and places a copy of the telephone order in to the code status notebook on the unit to replace the previous status sheet. The hand written order is then placed into the physician's folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. In the event an alert and oriented resident or a POA/responsible party desires to change a resident's code status, the physician will be contacted immediately to request a telephone order to change the code status. The nurse will write physician telephone order, transcribe it into the Electronic Health Record, and place a copy of the telephone order in the code status notebook on the unit to replace the previous status sheet. The hand-written order is then placed into the physician's folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. In-service training began 11-6-2013 and completed on 11-11-2013 with licensed nurses related to properly receiving, writing and transcribing physician orders and clarification of orders when the order fails to be clear and concise. **Monitoring/QA:** All new physician orders will be reviewed in morning clinical meeting (Monday-Friday) consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Nurse, Rehab Manager and Social Worker on-going. On weekends and	

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F 309	Continued From page 14 the family member gave permission because she was her power of attorney." On 11/7/13 at 2:19 pm, Nurse # 3 stated she recalled talking to the resident 's hcpoa on the phone and after she came in to the facility around 6:40 pm on October 18, 2013 regarding the new doctor 's order for full code status for Resident #1. Nurse #3 further stated the resident 's hcpoa did tell her that she was going to discuss with the resident her decision for full code status after she arrived in the building on the evening of October 18, 2013. She further indicated she did not speak to the hcpoa after the hcpoa visited with the resident because she had already left for the day. During an interview on 11/5/13 at 11:10 am, the Social Worker stated she did not accept the order from the nurse because there was nothing to get permission from the family for. The social worker further indicated Resident #1 was alert and oriented and could make her own decisions about her directives. She stated she told the nurse she would go in and speak with the resident because the resident told her she wanted to be a DNR when she completed her assessment with her. The Social Worker further indicated she did go in and speak with the resident on the afternoon of October 18, 2013 prior to leaving work around 5 pm. She further stated the resident informed her she wanted to be a DNR when she went to see her before leaving work on the same date. The Social Worker stated she did not go back to the nurse and let her know that the resident told her she wanted to be a DNR after the discussion of the order for full code. The Social worker further stated she did not see the nurse again before she left the building. She further stated she did not tell the nurse on Monday the 21st of October of the	F 309	holidays, the RN supervisor or designee will review all new physicians orders on-going. All Physician orders will continue to be reviewed with a second check by another licensed nurse to ensure physician order was transcribed correctly. In the event there is an area of identified concern related to physician order transcription, the correction will be made accordingly at that time. In addition, if there is any questionable concern related to the physician's order, the physician will be contacted by a licensed nurse to get clarification of order from physician. In the event an alert and oriented resident expresses a desire to change code status, or the POA of a resident who is unable to make decisions expresses the desire to change code status, the social worker will notify a licensed nurse immediately. According to Autumn policy, the nurse will call the physician immediately and obtain a telephone order. The nurse then writes the telephone order, transcribes the order into the Electronic Health Record and places a copy of the telephone order in to the code status notebook on the unit to replace the previous status sheet. The hand written order is then placed into the physician's folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. During the morning clinical meeting (Monday through Friday), consisting of Director of Nursing, Assistant Director of Nursing, Administrator, Care Plan Coordinators, Rehab Manager and Social Worker in attendance, Care Plan Coordinator	

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F 309	Continued From page 15 resident 's conversation with her about DNR after the discussion of the doctor's order for full code. The social worker further indicated it was the responsibility of the nursing staff to key in the order for the code status changes into the computer system. The Social Worker stated she confirms the code status orders in the computers quarterly. A review of the Meal Service Times schedule revealed "Dinner- 5:30 pm. A- hall Cart 6:00 pm." On 11/6/13 at 1:35 pm, during an interview, NA #1 stated Resident #1 was sleepy on the evening of October 18, 2013 but she responded appropriately when spoke to. NA #1 stated she went in to the resident 's room at the beginning of her shift and put the chairs up. She further stated she went back to check on the resident about 15 minutes before the meal trays came to the floor. NA #1 stated when she went back to deliver the dinner tray she stated to the resident for her to sit up so she could eat and the resident replied " I will baby." Review of the nurse 's note dated 10/21/13 at 6:31 pm by Nurse #1 revealed "writer into resident 's room and unable to arouse resident, sternal rub and stimuli uneventful. 100 hall nurse assisted writer and still no arousal. No heartbeat or pulse felt. Resident is a DNR. Call placed to MD (medical doctor). RP (responsible party) made aware and stated "I will be there in a few minutes. Awaiting her arrival. (6:20 pm)." On 11/5/13 at 8:55 am, in an interview with Nurse #1 revealed she found Resident #1 unresponsive on October 21, 2013 at approximately 6 pm. She stated she walked by Resident #1 's room and noticed she had not touched her dinner tray which	F 309	will notify the social worker of the residents who are in their 7 day assessment window. The social worker will then take that list of residents and verify code status with resident, POA or Responsible party (whichever applicable) as it relates to patient wishes. The social worker will then verify code status with resident, POA or Responsible party (whichever applicable) as it relates to patient wishes. Social worker will also document this conversation in the Electronic Health Record immediately. The Care Plan Coordinator will compare that the Social Workers documentation is in agreement with the current physicians order. Audits will then be done by the Care Plan Coordinator on 5 residents a month x 4 months and then 10 residents quarterly on-going. Every resident who has had a change in code status will be audited by Medical Records weekly x 4 weeks and then monthly on-going to ensure the code status book has been updated at the appropriate nurses station. All new admissions will be audited by Day 3 of admission by social worker to confirm code status is correct on-going. Bi-weekly audits x 2 months began on 10-22-13 by Medical Records, ADON and Social worker. Additionally 5 resident records will be audited bi-weekly x 2 months by the Director of Nursing or Assistant Director of Nursing to ensure current code status and physician orders agree. An audit of all residents who have expired in the facility since 10-22-2013 began 11-07-2013 by the Medical Records Clerk to	

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F 309	Continued From page 16 was unusual for the resident. Nurse #1 stated Resident #1 was without pulse or heartbeat and her body was warm. She further indicated the resident 's eyes were dilated. She stated she was unable to arouse Resident #1 by firmly rubbing on the resident 's chest so she went to get Nurse #2 to verify with her because the resident was a DNR. Nurse #1 stated she checked the code status book on the floor and it contained the DNR order for Resident #1. In an interview on 11/6/13 at 3:24 pm, Nurse #2 stated she was asked by Nurse #1 to come to Resident #1 's room to verify her death. Nurse #2 stated there were no pulse and no heartbeat. She further stated she verified with Nurse #1 that the resident had expired. Nurse #2 stated the resident 's body was still a little warm with her arms straight by her side. Nurse #2 stated she returned to her assigned area after advising Nurse #1 to call the doctor to pronounce the death. She further stated she did not verify the code status for Resident #1. She stated the assigned nurse for Resident #1, Nurse #1 had informed her that the resident 's code status was DNR. On 11/5/13 at 12:02 pm, during a phone interview with the attending physician, he stated he expected the nursing staff to carry out the order as written. The physician stated he wrote the order because the resident was alert and oriented and requested it. He further stated because the resident and the family made one decision at the hospital did not mean they could not change their mind about their directives later. The physician further indicated his plan was for the staff to contact the family member who was the health care power of	F 309	confirm the code status was followed on-going. Any area of identified concern will be addressed immediately and will be addressed in Quality Assurance meetings for further action plans during morning meetings.	

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F 309	Continued From page 17 attorney (hcpoa) to make sure she was aware of the resident ' s decision for full code to ensure everyone was on the same page. In an interview on 11/5/13 at 12:13 pm, the Director of Nursing (DON) indicated the facility Physician Order Sheet is an order and under no circumstances should the nurse not have carried the order out given by the doctor. The DON further indicated she expected the nurse to process the order for the code status change into the computer, discontinue the DNR order and put in the full code order. The DON further indicated the nurse should have pulled the DNR order out of the code status book at the nurse ' s station. She further indicated the nurses are expected to verify the resident ' s code status via the quickest resource whether it is the computer or the code status book at the nurse 's station. The DON further indicated the nurse should have notified the physician that gave the order immediately if for any reason she was unable to carry out the doctor 's order. On 11/5/13 at 3:48 pm, during an interview, the Assistant Director of Nursing (ADON) stated she was not aware of the order for full code for Resident #1 until after the resident had passed away. The ADON stated Nurse #3 came to her with the order the day after the resident had passed away. She stated she immediately called the administrator and the DON who was out of the building and informed them. The ADON stated she did not give instructions to Nurse #3 not to transcribe the order for code status change. The facility provided the following Credible	F 309		

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F 309	Continued From page 18 Allegation on November 7, 2013 at 7:15 pm. Credible Allegation of Compliance: F-Tag 309 For the Provision of Care to Maintain the highest level of function for residents. Resident # 1 was admitted to facility on 10/15/2013 and on 10/16/2013 the attending physician wrote an order for resident to be a DNR. Resident # 1 also admitted with a signed and notarized Advanced Directive for a Natural Death (" Living Will ") which was initialed by Resident #1 to "withhold or withdraw life-prolonging measures" . Item #6 of the Advanced Directive states "If I have an Available Health Care Agent: If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that: Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life. Advanced Directive was dated and notarized 10/07/13. After the physician order was written on 10/18/13 for a full code, the lead licensed nurse alerted the Social Worker and the Social Worker visited with resident in her room that same afternoon and the resident expressed her wishes to remain DNR. The social worker documented the "status is DNR " in her note that was written on 10-21-2013 at 15:40. The resident was found to be unresponsive by licensed nurse on 10-21-13 at 18:00. The nurse documented at 18:31 that there was no pulse or heart beat and that the code status was DNR.	F 309		

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F 309	Continued From page 19 This facility identified the discrepancy to be resident #1 's wishes to be DNR status conflicted with the most recent physician order for Full Code Status on 10-22-13. After a completed audit on 10-22-13 through 10-25-13 was done, it was discovered that this was an isolated event due to no other affected areas. An audit was completed on 11-05-13 for all new admissions from 10-25-13 through 11-05-13 in which no affected areas were found. There were three technical changes that were made during the audit which were as follows: A DNR order for resident E.G. was in the Electronic Health Record appropriately, but the physical order had not yet been scanned and attached to the order in the Electronic Health Record. Medical Records Clerk scanned the document into Electronic Health Record. In one case, the demographics section on resident S.W. showed a "yes" for having a living will but the resident does not have one. This was changed appropriately and does not affect resident 's code status. Also, resident S.C. 's " yes " / " no " question in Demographics section was marked "no" , however, there was a written order scanned in the system, the system accurately reflected DNR in the chart, and the yellow DNR form was in the Code Status Book at the appropriate nurses station. A new code status communication form was implemented on 11-05-2013 specifically for the Social Worker to utilize in the event the resident expresses wishes other than the current status order. Social Worker received in-service on 11-05-13 by Administrator to ensure the wishes of the resident are conveyed to appropriate staff. Licensed nurses in-serviced on communication form implemented on 11-05-13 starting on	F 309		

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11-06-13 and any licensed staff who do not receive in-service education on 11-06-13 will be required to receive in-service training prior to their next scheduled tour of duty. The Administrator and Director of Nursing were out of town at a conference and mandated that a complete audit be performed on all other in-house residents to verify accuracy of code status reflected according to resident wishes by the Social worker, ADON and Medical Records. Audit consisted of validating the physician ' s order and current documents in place were in agreement current code status. Educational In-Service was provided by ADON to Medical Records and Social Services staff for resident code status, HCPOA, Living Wills and verification in Electronic Medical Record and code status book, which is maintained on each unit on 10/22/2013. The in-service education provided consisted of verification of most recent physician 's order with the most current Advanced Directives documents in agreement as indicated. Licensed nurses received in-service training beginning on 11-05-13 on receiving physician orders and transcription of physician orders and validating that most current physician ' s order is in agreement with documents in place according to wishes for code status and physician 's order. Any licensed nurse not receiving the in-service on 11-05-13 will be required to receive in-service training prior to their next scheduled tour of duty.

The facility will continue to determine resident ' s desires and wishes upon admission related to code status by the Admission Coordinator. The Admission Coordinator will continue to communicate this information to Medical Records and the licensed nurse in order to review the resident ' s code status with the physician in order

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	345280	A. BUILDING _____ B. WING _____	C 11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON ST RAEFORD, NC 28376

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F 309	Continued From page 21 to obtain a physician ' s order for the appropriate order for code status according to Autumn Policy. Once resident and/or POA has conveyed wishes, licensed nurse will call the attending physician for appropriate order. The nurse then writes the telephone order, transcribes the order into the Electronic Health Record and places a copy of the telephone order in to the code status notebook on the unit to replace the previous status sheet. The hand written order is then placed into the physician ' s folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. In the event an alert and oriented resident or a POA/responsible party desires to change a resident ' s code status, the physician will be contacted immediately to request a telephone order to change the code status. The nurse will write physician telephone order, transcribe it into the Electronic Health Record, and place a copy of the telephone order in the code status notebook on the unit to replace the previous status sheet. The hand-written order is then placed into the physician 's folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. All new physician orders will be reviewed in morning clinical meeting (Monday-Friday) with the Administrator, Director of Nursing, ADON, MDS Nurse, Rehab Manager and Social Worker on-going. On weekends and holidays, the RN supervisor or designee will review all new physicians orders on-going. All Physician orders will continue to be reviewed with a second check by another licensed nurse to ensure physician	F 309		

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F 309	Continued From page 22 order was transcribed correctly. In the event there is an area of identified concern related to physician order transcription, the correction will be made accordingly at that time. In addition, if there is any questionable concern related to the physician 's order, the physician will be contacted by a licensed nurse to get clarification of order from physician. In the event an alert and oriented resident expresses a desire to change code status, or the POA of a resident who is unable to make decisions expresses the desire to change code status, the social worker will notify a licensed nurse immediately. According to Autumn policy, the nurse will call the physician immediately and obtain a telephone order. The nurse then writes the telephone order, transcribes the order into the Electronic Health Record and places a copy of the telephone order in to the code status notebook on the unit to replace the previous status sheet. The hand written order is then placed into the physician 's folder to be signed upon his next visit. After the physician signs the order, the Medical Records Clerk then scans and attaches the order into the Electronic Health Record. During the morning clinical meeting (Monday through Friday), with DON, ADON, Administrator, MDS nurses Rehab Manager and Social Worker in attendance, MDS nurse will notify the social worker of the residents who are due for assessment on that day. The social worker will then verify code status with resident, POA or Responsible party (whichever applicable) as it relates to patient wishes. Social worker will also document this conversation in the Electronic Health Record immediately. The MDS Nurse will verify that the Social Workers documentation is in agreement with the current physicians order.	F 309		

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F 309	Continued From page 23 In-service training began 11-6-2013 with licensed nurses related to properly receiving, writing and transcribing physician orders and clarification of orders when the order fails to be clear and concise. In-services will be complete on 11-6-2013 and any nurse identified not attending will require in-service training prior to beginning their next scheduled tour of duty. To ensure that all new admissions are not affected, the admission coordinator will continue to discuss Advance Directives/Code Status with resident and/or POA and obtain/request copies of documents pertaining to Advance Directives. Admissions Coordinator then alerts Medical Records and Nurse in Charge of resident and/or POA of code status. Nurse will call Physician and request telephone order per residents' and/or POA 's code status. Medical records will obtain all pertinent documents related to code status and scan in to Electronic Medical Record. In the event that a resident ' s code status changes during their stay at the facility, the social worker and/or licensed nurse will notify attending physician or designee for an order to honor resident and/or POA wishes immediately. Licensed nurses received in-service education starting 11-06-13 in reference to resident 's who are alert and oriented having the right to convey choices and those choices are to be honored as it relates to code status. This facility will continue to ensure that current code status is reflected in the medical record and in the notebooks on each unit which contains the face sheets and code status sheets. After the nurse obtains the telephone order from the doctor to change the code status, the nurse will then	F 309		

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F 309	Continued From page 24 remove the previous code status sheet and insert a copy of the telephone order. On 11/7/2013 at 7:15 pm, verification of the credible allegation was evidenced by interviews of licensed nursing staff related to transcription of orders and the need to notify the physician immediately if an order needs to be clarified. Nurses verified orders for code status changes are to be transcribed as stat orders. Verification of the credible allegation continued with interviews of licensed nursing staff and social worker related to the new communication form if residents express a desire for code status change to the social worker. The social worker and nursing verified the form would be initiated by the social worker and forwarded to the nursing staff.	F 309		