STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER ROAD ELIZABETHTOWN, NC 28337

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 11/08/18. Event ID #7YO111.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		11/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/19/2018

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to resolve discrepancy regarding code status for 1 of 2 sampled residents (Resident #76) whose code status were reviewed. Findings included: Record review revealed Resident #76 was admitted to the facility on 09/07/18, and most recently admitted to the facility on 10/08/18 following hospitalizations. The resident's documented diagnoses included history of anoxic brain damage, Coronary Artery Disease (CAD), Myocardial Infarction (MI), seizure disorder, hypertension (HTN), dementia, pneumonia, and Diabetes (DM). The code status most recently documented in Resident #76's electronic and paper medical record was a physician order for "full code" dated 09/07/18. Record review revealed there was not a current physician order regarding code status in Resident #76's electronic medical record. Her code status was documented as "full code" dated 09/07/18. Record review revealed the last code status	F 578	The Plan of Correction is prepared as a necessary requirement for the continued participation in the Medicare and Medicaid program(s). Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be interpreted as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's allegation of compliance. Resident #76 has been discharged from facility. Identification of other residents having the potential to be affected was accomplished by: Determining the code status or presence / absence of Advance Directives is required for all residents. Therefore, all residents have the potential to be affected.	

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F 578	Continued From page 2 documented in Resident #76's electronic medical record was "full code" which was effective from 09/07/18 through 09/17/18. On 11/09/18 at 3:00 PM Resident #76's paper medical record was examined and there were the following forms: care plan with code status listed "full code", face sheet with code status listed "full code", and code status form with code status listed "full code" all dated 09/07/18. A social services note dated 09/07/18 revealed Resident #76's responsible party (RP) received a copy of the bill of rights, policy manual and advance directives. Her stay was anticipated to be short term for therapy. She was a "full code". A hospital palliative care consult note dated 09/27/18 at 5:07 PM for hospice and palliative care evaluation and recommendations for Resident #76 revealed consult an extensive discussion with the family member by the bedside. Family wanted the patient to be "do not resuscitate" (DNR)/"do not intubate") DNI and order was placed. The resident had a hospital DNR form in the resident's chart dated 09/21/18. A hospital discharge summary dated 10/08/18 for Resident #76 revealed palliative care was consulted for goals of care, and was currently DNR/DNI. A Medical Director (MD) progress note dated 10/09/18 for Resident #76 revealed resident was admitted to the skilled nursing facility (SNF) for palliative care. Family of resident assigned patient as DNR/DNI. The resident's family reportedly requested no reintubation if indicated and that patient's code status remain DNR/DNI.	F 578	Actions taken / systems put into place to reduce the risk of future occurrence include: The Administrator re - educated the Director of Social Services and licensed nurses regarding the documentation procedures for Advance Directives / Code Status. A chart audit of all residents was completed on 11/14/2018. No discrepancies noted. Please see Attachments: "Record of In-Service Training and Attendance Form" Pages: 1 "Validation Checklist" Code Status Pages: 3 "Policy - Communication of Code Status" Pages: 1 "Practice Guideline" Pages: 1 "QA Work Document" Pages: 1 How the corrective action(s) will be monitored to ensure the practice will not recur: For a period of three months, the Director of Social Services will perform weekly paper and electronic medical record audits of new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident's Advance Directives / Code Status. After three months, the Director of	

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F 578	Continued From page 3 A palliative care consultation was done with family (including RP). Family members elected to have patient assigned as DNR/DNI. Resident's family members were made aware of patient's poor prognosis and guarded medical status. Family requested that patient be discharged to the nursing center instead of intermediate care facility for palliative care since patient had been employed there in the past, she would be among friends. Disposition planning team honored family's request to have patient discharged to the skilled nursing facility with the understanding that patient was DNR/DNI. Patient required total care, and had a poor prognosis. Patient was admitted to the SNF for palliative care only. Code status was DNR/DNI while hospitalized. Family requested no further work-up for patient's acute, life-threatening medical issues, and to re-establish DNR/DNI code status. Resident #76's 10/15/18 minimum data set (MDS) documented the resident had severe cognitive impairments. A nursing note date 10/19/18 at 3:44 PM revealed at approximately 7:00 PM Resident #76 was found with no respirations, no pulse, with cardio-pulmonary resuscitation (CPR) initiated at that time. CPR continued for approximately 5 minutes until emergency medical services (EMS) arrived and took over rescue efforts. Resident left facility at approximately 7:30 PM via stretcher per EMS staff with continued rescue efforts. A nurse called with report from hospital. The resident's RP was notified by phone. Prior to cardiac event resident had rested well throughout shift. Her blood sugars were increased at 398 which was normal for resident and resident was given sliding scale insulin as ordered. Her	F 578	Social Services will complete a random medical record audit of at least 10 records for consistent documentation. Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained.	

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F 578	Continued From page 4	F 578		

oxygenation was at 97% with pulse of 100. Resident was on oxygen at 2 liters per minute via nasal cannula.

An interview on 11/08/18 at 10:53 AM with the Medical Director (MD) and Director of Nursing (DON) revealed Resident #76's code status should have been changed by the facility staff from "full code" to "DNR/DNI" on 10/08/18 to reflect resident's family/RP wishes, and was not. The MD stated the facility should have obtained a verbal confirmation for code status from the resident's RP at the time of admission, which they did not. The MD provided a copy of the facility's code status procedure dated 10/2006, which read in part, "If the resident representative (RP) is unable to sign the DNR Code Status Form immediately, a verbal confirmation witnessed by two nurses was acceptable until a signed DNR Code Status Form was obtained". The MD and DON said the facility failed to update the resident's code status, and failed to call the RP for a verbal confirmation in order to confirm code status. The MD said, she and the facility dropped the ball, and that Resident #76 should have been re-instated as a DNR/DNI upon admission on 10/08/18, and had not.