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F 155 SS=E	RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES CFR(s): 483.10(c)(6)(8)(g)(12), 483.24(a)(3) 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. 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. (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 155		11/15/17

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

Electronically Signed | 11/10/2017

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F 155	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. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, the facility failed to assist residents and or their responsible parties in establishing code status upon admission. This affected 3 of 5 sampled residents (Residents #151, #204 and #202). The findings included: The facility's Advance Directives policy revised February 2017 included the procedures: 1. Upon admission the facility will provide a resident or resident's legal representative with written information regarding the facility's policies on advance directives and a copy of this policy; 4. If a resident has not executed an advanced directive and the resident has the capacity to make health care decisions, the Social Services Department should inquire whether the resident wishes to make an advance directive;	F 155	F155 (E) Right to Refuse, Formulate Advance Directives The processes that lead to the deficiency cited; The Social Worker failed to follow Advanced Directive Policy and nursing failed to follow up on Advanced directives per policy How will corrective action be accomplished for those residents found to have been affected by the deficient practice: On 10-24-17, code status, DNRs, electronic health record physician□s orders, care plans and face sheets were reviewed for residents #152, #204, and #202 to confirm all necessary advance directive documentation was in place. On	

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F 155	Continued From page 2 5. If a resident has not executed an advance directive and does not have the capacity to do so at the time of admission, then the facility must follow state law to determine who has authority to make health care decisions on behalf of the resident; 6. The facility must document in a prominent part of the resident's clinical record whether the resident has issued an advance directive; and 7. The facility's copy of the advance directive must be filed in the resident's clinical record. The facility's policy titled "Admission to the Facility" revised August 2017 included the procedure: 2. If the resident has an appointed legal representative, the identifying paperwork is obtained prior to or upon admission. If no legal representative exists upon admission, the facility staff shall encourage the resident to execute a power of attorney for healthcare and an advance directive. 1. Resident #151 was admitted to the facility on 10/03/17. Review of the medical record revealed no code status was noted on the face sheet in the computer record or in the paper record's face sheet. The record had no golden rod "Do Not Resuscitate" (DNR) form and no hot pink Medical Orders for Scope of Treatment (MOST) form. Review of the computerized physician orders for October 2017 revealed no advance directive orders. Nursing notes dated 10/20/17 at 4:24 AM, written by Nurse #2, revealed she was notified by nurse aide that the resident was found unresponsive when doing rounds. Nurse went to the room and	F 155	10-25-17, the Administrator completed a Teachable Moment with the Social Worker and Director of Nursing on expectations regarding obtaining code status upon admission and/or readmission and the protocol for Advance Directives. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 11-10-17, an audit was completed by, MDS coordinator and Social Worker to ensure no other advance directives were missed, incomplete and/or outstanding. Any identified issues were corrected immediately. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 11/10/17 , licensed nurses, the Social Worker and the interdisciplinary team were re-educated by the Staff Development Coordinator on the requirements for compliance with F155 with emphasis on the facility policy for Advance Directives. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Social Worker and Director of Nursing and/or Nurse Managers will monitor corrective actions to ensure the	

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F 155	Continued From page 3 found no palpable pulse and no respirations. Her pupils were fixed and dilated. Confirmed by the primary care provider, no cardiopulmonary resuscitation (CPR) was performed. The registered nurse went to room and the resident's death was pronounced at 2:50 AM. A physician's telephone order dated 10/20/17 at 3:05 AM stated "Patient is DNR status, Do not call 911, do not send out to hospital - Pt (patient) has expired-" This was signed by Nurse #1. Nurse #1 was interviewed via telephone on 10/23/17 at 4:34 PM. Nurse #1 stated Nurse #2 thought Resident #151 was DNR status but when Nurse #1 looked in the chart she did not find the golden rod DNR sheet. She stated she found notes in the chart that indicated the family wanted DNR status and called the physician. She conveyed this finding to the physician who ordered the DNR status and orders to not start CPR on the telephone order dated 10/20/17 at 3:05 AM. An interview was conducted with Nurse #2 on 10/23/17 at 7:12 PM. Nurse #2 stated on 10/20/17 she responded to Resident #151 and had the nurse aide obtain the resident's medical record. Nurse #2 stated she had the nurse aide get the registered nurse (Nurse #1) to assist her. She and the registered nurse looked at the paper chart expecting to find a golden rod DNR or pink MOST form. in the front of the chart. Not finding either, Nurse #2 stated they flipped through the paper chart until they found a hospital note that stated, on the same sheet of paper, the resident was both full code and that the family wanted Resident #151 to be DNR. Nurse #2 stated Nurse #1 ran out and stated she had to clarify	F 155	effectiveness of these actions by monitoring new admissions to ensure the timely and complete processing of advance directives weekly X 4 weeks, then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services to maintain compliance when completing facility reviews.	

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with the physician the code status. Nurse #1 subsequently called the resident's physician, who happened to also be on call, and he gave the directive to not do cardiopulmonary resuscitation per the hospital note.

Interview with the Medical Director on 10/23/17 at 11:54 AM revealed he expected that on any admission, including readmission, the advance directives were to be reviewed. He further stated that without any advance directives established he would expect staff to proceed with full code when a resident was found without respirations.

Interview with the Admissions Coordinator on 10/23/17 at 12:15 PM revealed the Social Worker discussed advance directives with the resident and or family. On follow up interview conducted on 10/24/17 at 8:29 AM, the Admissions Coordinator stated she provided a paper on advance directives for review but did not explain anything about advance directives.

Interview with the Director of Nursing on 10/23/17 at 1:38 PM revealed code status could be established via a telephone order or put directly in the electronic record. She stated the facility was trying to establish the use of the pink MOST forms, which specified the scope of treatment chosen by the resident but that system was not a mandatory process in this facility.

Interview with the social worker (SW) on 10/23/17 at 5:04 PM revealed the code status should be in the computer directly under the resident's picture. When reviewing Resident #151's computer record, she verified no code status was listed. She further stated that typically the admitting nurse would put in the code status. Upon the

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admission on 10/03/17 there was no evidence that a code status was established and per SW that would mean the resident would automatically be a full code. SW stated that the Admissions Coordinator used to begin the process with the MOST form, however, around the beginning of September 2017, a Nurse Practitioner who was no longer working for the facility, wanted the initiation to be by a clinical staff person and instructed the Admissions Coordinator to put the form in the front of the chart for follow up. SW stated she was finding that the MOST form was not being completed and as of last Thursday she decided to start trying to establish code status on residents who had no goldenrod or MOST form. She stated she did this on her own accord and was not instructed to do so by any administrative staff. She further stated the unit manager put in the code status in the computer upon admission.

Interview with Nurse #3 on 10/23/17 at 5:31 PM revealed she regularly admitted new residents to the facility. Nurse #3 stated that she did not talk to residents about code status and it was her understanding that the social worker helped obtain advance directives. If there was no code delineated in the medical chart, she stated this meant staff were to initiate resuscitation efforts.

On 10/24/17 at 2:12 PM the Unit Manager stated during interview that she was responsible for verifying admission orders and putting them in the computer. She stated she introduced herself to residents and if present family on admission but did not discuss code status with either. She stated that if there was a code status stipulated via admission hospital papers, she verified those with the physician. If there was no indication that there were advance directives, she automatically

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made the resident a full code.

During an interview with the Administrator on 10/24/17 at 2:36 PM, she stated her expectation was that a code status would be clarified with the physician. She stated if a resident was admitted with no code status determined the facility should determine a code status as quickly as possible. She stated social services played a large role in establishing code status with the use of the MOST form by initiating its use. She further stated the golden rod DNR form was used for transfers out of the facility but she could not say if a golden rod form was routinely established and used in this facility. The administrator stated that it should not take the facility 4 to 5 days to establish a code status for a resident and the system needed to be "tightened."

2. Resident #204 was admitted to the facility on 10/19/17. Nursing notes dated 10/19/17 at 3:44 PM he arrived from home with family and was alert and oriented to person place and time with some short and long term memory loss.

Review of his medical record on 10/23/17 revealed physician orders were obtained on 10/23/17 for him to be a full code. This was also stipulated under his picture identification in the computerized record. The record had no golden rod "Do Not Resuscitate" (DNR) form and no hot pink Medical Orders for Scope of Treatment (MOST) form.

An interview on 10/24/17 at 8:58 AM with the admitting nurse (Nurse #4) revealed the code order was obtained by the second shift supervisor, Nurse #5. Nurse #4 stated if there was no code status listed, she would initiate

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cardiopulmonary resuscitation.

An attempt to contact Nurse #5 via phone was unsuccessful.

Review of the care plan for Resident #204 revealed a care plan, established 10/24/17, for this resident having advance directives honored and stipulated he was a full code.

A secondary chart review on 10/24/17 revealed Resident #204's medical record had a revised physician order dated 10/24/17 at 11:03 AM making him a Do Not Resuscitate (DNR).

Resident #204's power of attorney/family was interviewed via phone on 10/24/17 at 1:21 PM This family stated that she accompanied Resident #204 to the facility on 10/19/17. She stated that no one discussed code status with her until this morning during a care plan meeting. She stated that she informed the facility staff that Resident #204 had always wanted to be DNR and that was what she wanted for him.

Interview with the Medical Director on 10/23/17 at 11:54 AM revealed he expected that on any admission, including readmission, the advance directives were to be reviewed. He further stated that without any advance directives established he would expect staff to proceed with full code when a resident was found without respirations.

Interview with the Admissions Coordinator on 10/23/17 at 12:15 PM revealed the Social Worker discussed advance directives with the resident and or family. On follow up interview conducted on 10/24/17 at 8:29 AM, the Admissions Coordinator stated she provided a paper on

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advance directives for review but did not explain anything about advance directives.

Interview with the Director of Nursing on 10/23/17 at 1:38 PM revealed code status could be established via a telephone order or put directly in the electronic record. She stated the facility was trying to establish the use of the pink MOST forms, which specified the scope of treatment chosen by the resident but that system was not a mandatory process in this facility.

Interview with the social worker (SW) on 10/23/17 at 5:04 PM revealed the code status should be in the computer directly under the resident's picture. She further stated that typically the admitting nurse would put in the code status. SW stated that the Admissions Coordinator used to begin the process with the MOST form, however, around the beginning of September 2017, a Nurse Practitioner who was no longer working for the facility, wanted the initiation to be by a clinical staff person and instructed the Admissions Coordinator to put the form in the front of the chart for follow up. SW stated she was finding that the MOST form was not being completed and as of last Thursday she decided to start trying to establish code status on residents who had no goldenrod or MOST form. She stated she did this on her own accord and was not instructed to do so by any administrative staff. She further stated the unit manager put in the code status in the computer upon admission.

Interview with Nurse #3 on 10/23/17 at 5:31 PM revealed she regularly admitted new residents to the facility. Nurse #3 stated that she did not talk to residents about code status and it was her understanding that the social worker helped

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obtain advance directives. If there was no code delineated in the medical chart, she stated this meant staff were to initiate resuscitation efforts.

On 10/24/17 at 2:12 PM the Unit Manager stated during interview that she was responsible for verifying admission orders and putting them in the computer. She stated she introduced herself to residents and if present family on admission but did not discuss code status with either. She stated that if there was a code status stipulated via admission hospital papers, she verified those with the physician. If there was no indication that there were advance directives, she automatically made the resident a full code. Upon follow up interview with the Unit Manager on 10/24/17 at 3:11 PM, she revealed that she took the admitting orders for Resident #204 and with no stipulating code status she made him a full code. She went on to explain that there was a 72 hour care plan meeting for Resident #204 this date and the family stated he wanted to be a DNR so the orders were subsequently changed this date.

During an interview with the Administrator on 10/24/17 at 2:36 PM, she stated her expectation was that a code status would be clarified with the physician. She stated if a resident was admitted with no code status determined the facility should determine a code status as quickly as possible. She stated social services played a large role in establishing code status with the use of the MOST form by initiating its use. She further stated the golden rod DNR form was used for transfers out of the facility but she could not say if a golden rod form was routinely established and used in this facility. The administrator stated that it should not take the facility 4 to 5 days to establish a code status for a resident and the

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system needed to be "tightened."

Interview with Minimum Data Set staff on 10/24/17 at 3:31 PM revealed the care plan was established for full code when the order for full code status was obtained. MDS staff continued stating that as of this date's 72 hour care plan meeting, the family, who is power of attorney, expressed the desire to have him be a DNR and the care plan will be updated.

3. Resident #202 was admitted to the facility on 10/19/17. Social service initial assessment and history dated 10/19/17 noted that Resident #202 had intact memory and was oriented to self, family, time, place and situation. She was also noted to be independent with decision making. Under the section of advance directives it was noted that the resident's rights have been reviewed with the resident. There was no notation as to the decision relating to her choice of advance directives.

Review of the medical record revealed Resident #202's code status was not established until 10/23/17. Resident #202's code status was full code and a care plan was subsequently established on 10/23/17 for her to be full code. The order was written on 10/23/17 by the Unit Manager. There was no hot pink Medical Orders for Scope of Treatment (MOST) found in the medical record.

Interview with the Medical Director on 10/23/17 at 11:54 AM revealed he expected that on any admission, including readmission, the advance directives were to be reviewed. He further stated that without any advance directives established he would expect staff to proceed with full code

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when a resident was found without respirations.

Interview with the Admissions Coordinator on 10/23/17 at 12:15 PM revealed the Social Worker discussed advance directives with the resident and or family. On follow up interview conducted on 10/24/17 at 8:29 AM, the Admissions Coordinator stated she provided a paper on advance directives for review but did not explain anything about advance directives.

Interview with the Director of Nursing on 10/23/17 at 1:38 PM revealed code status could be established via a telephone order or put directly in the electronic record. She stated the facility was trying to establish the use of the pink MOST forms, which specified the scope of treatment chosen by the resident, but that system was not a mandatory process in this facility.

Interview with the social worker (SW) on 10/23/17 at 5:04 PM revealed the code status should be in the computer directly under the resident's picture. She further stated that typically the admitting nurse would put in the code status. SW stated that the Admissions Coordinator used to begin the process with the MOST form, however, around the beginning of September 2017, a Nurse Practitioner who was no longer working for the facility, wanted the initiation to be by a clinical staff person and instructed the Admissions Coordinator to put the form in the front of the chart for follow up. SW stated she was finding that the MOST form was not being completed and as of last Thursday she decided to start trying to establish code status on residents who had no goldenrod or MOST form. She stated she did this on her own accord and was not instructed to do so by any administrative staff. She further stated

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the unit manager put in the code status in the computer upon admission.

Interview with Nurse #3 on 10/23/17 at 5:31 PM revealed she regularly admitted new residents to the facility. Nurse #3 stated that she did not talk to residents about code status and it was her understanding that the social worker helped obtain advance directives. If there was no code delineated in the medical chart, she stated this meant staff were to initiate resuscitation efforts.

On 10/24/17 at 2:12 PM the Unit Manager stated during interview that she was responsible for verifying admission orders and putting them in the computer. She stated she introduced herself to residents and if present family on admission but did not discuss code status with either. She stated that if there was a code status stipulated via admission hospital papers, she verified those with the physician. If there was no indication that there were advance directives, she automatically made the resident a full code.

During an interview with the Administrator on 10/24/17 at 2:36 PM, she stated her expectation was that a code status would be clarified with the physician. She stated if a resident was admitted with no code status determined the facility should determine a code status as quickly as possible. She stated social services played a large role in establishing code status with the use of the MOST form by initiating its use. She further stated the golden rod DNR form was used for transfers out of the facility but she could not say if a golden rod form was routinely established and used in this facility. The administrator stated that it should not take the facility 4 to 5 days to establish a code status for a resident and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 10/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	**1870 PISGAH DRIVE HENDERSONVILLE, NC 28791**

(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 155	Continued From page 13 system needed to be "tightened."	F 155		