

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2017
NAME OF PROVIDER OR SUPPLIER JAMES SQUARE NURSING AND REHAB CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 918 JAMES STREET SYRACUSE, NY 13203	
(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) COMPLETE DATE
F 155 SS=G	<p>483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>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.</p> <p>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.</p> <p>(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(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.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(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.</p> <p>(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</p>	F 155	<p>F- 155 - This Plan of Correction is required by federal and state regulations and is not to be construed as an admission that the cited deficiencies are accurate or that at the time of the survey the facility did not have policies, procedures and systems in place to maintain compliance with federal and state requirements.</p> <p>Corrective action for resident(s) affected: Resident #1: Resident was transferred to the hospital for evaluation. The resident returned that day and remains at her baseline. No harm resulted to the resident.</p> <p>A. Care plan and Kardex were reviewed and updated to reflect the resident's current MOLST form. B. Physician order reviewed and current. C. Verified resident's bracelet match resident's MOLST form. D. IDT and Physician reviewed plan of care.</p> <p>Identification of residents that could be affected by the deficient practice: All residents in a nursing home have the risk of being affected by this deficient practice if their medical condition or cognition changes suddenly or a resident has not been accurately assessed.</p> <p>A. In-house residents Advance Directives will be reviewed. Any discrepancies will be clarified and modified as needed. B. In-house residents care plans and kardexes will be reviewed for accuracy. C. Nursing Staff were educated on</p>	10/05/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____
Electronically Signed 10/12/2017

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2017	
NAME OF PROVIDER OR SUPPLIER JAMES SQUARE NURSING AND REHAB CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 918 JAMES STREET SYRACUSE, NY 13203		
(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) COMPLETE DATE
F 155	<p>Continued From page 1 individual's resident representative in accordance with State law.</p> <p>(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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation, and interview conducted during the abbreviated survey (NY00205627), it was determined the facility did not ensure 1 of 3 residents (Resident #1), reviewed for advance directives, had their advanced directives honored. Specifically, Resident #1 was resuscitated despite a Do Not Resuscitate (DNR) order included in the resident's medical record. This resulted in actual harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>The facility Advanced Directives policy dated 8/2012 and provided to the surveyor on 8/15/2017 at 11:25 AM, documented it was the policy of the facility to ensure resident/patients advanced directives be honored.</p> <p>An unsigned Code Blue Management policy was reviewed on 8/23/2017 and documented that if a</p>	F 155	<p>advance directive policy and how to identify when to implement interventions appropriately.</p> <p>Systemic Changes:</p> <p>A. Policies and Procedures were reviewed and modified on Advance Directives.</p> <p>B. All departments were educated on Advance Directives, including a review of all revised and pertinent policies and procedures.</p> <p>C. Upon hire all nursing staff employees (including agency and per diem) will complete education how to identify resident code status by bracelet worn by resident.</p> <p>D. To ensure knowledge of advanced directives for each resident, current nursing staff has been educated on how to locate resident code status using three means: Bracelet, physician order, Care plan, Kardex, MOLST form and red dot sticker on head board for DNR.</p> <p>E. Audit to be completed to demonstrate staff knowledge.</p> <p>Quality Assurance & On-going Monitoring:</p> <p>Advance Directive audits will be completed every week x 4 weeks, monthly x 3 months then review in QAPI.</p> <p>Audits will continue until 100% compliance</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2017	
NAME OF PROVIDER OR SUPPLIER JAMES SQUARE NURSING AND REHAB CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 918 JAMES STREET SYRACUSE, NY 13203		
(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) COMPLETE DATE
F 155	<p>Continued From page 2 resident experiences cardiac arrest, the facility will provide basic life support, including CPR in an accordance with the residents advanced directives until emergency services arrive.</p> <p>Resident #1 was admitted to the facility on 5/6/2013 and had diagnoses including above the knee amputation, chronic pain, anxiety and depression. The Minimum Data Set (MDS) assessment dated 6/9/2017 documented the resident's cognition was severely impaired and she required supervision with activities of daily living (ADL's).</p> <p>The Medical Orders for Life Sustaining Treatment (MOLST) form dated 8/18/2016 documented the resident did not want to be resuscitated, did not want to be intubated, wanted limited medical interventions, and wished to be sent to the hospital only if necessary.</p> <p>The comprehensive care plan (CCP) and resident care guide (care instructions) dated 3/22/2017 did not document the residents code status or advanced directives including any MOLST form directives.</p> <p>The physician's orders dated 6/12/2017 documented the resident's code status was Do Not Resuscitate (DNR), Do Not Intubate (DNI).</p> <p>The registered nurse (RN) progress note dated 8/13/2017 at 11:22 AM documented:</p> <ul style="list-style-type: none"> - licensed practical nurse (LPN) #1 provided the resident with her medication at which time the resident became unresponsive and no pulse or respirations were identified; - CPR was initiated by LPN#1; - RN #3 arrived on the unit, placed an artificial airway; 	F 155	is achieved and as seen appropriate by Nursing Home Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2017
NAME OF PROVIDER OR SUPPLIER JAMES SQUARE NURSING AND REHAB CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 918 JAMES STREET SYRACUSE, NY 13203	
(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) COMPLETE DATE
F 155	<p>Continued From page 3</p> <ul style="list-style-type: none"> - CPR continued for 1 minute at which time the resident responded; - LPN #2 stated the resident was a full code; and - after CPR was completed, RN #5 identified on the residents computerized chart the resident has a physician ordered DNR. <p>The facility investigation report dated 8/14/2017 documented:</p> <ul style="list-style-type: none"> - Resident #1 was witnessed unresponsive; - LPN #1 called for help; - LPN #2 approached the residents room, checked for pulse and respiration, and an "All Come Code" was called. - RN # 3, 4 and 5 responded and when they arrived on the unit were informed by LPN #2 the resident had a full code status. <p>During interviews conducted on 8/15/2017 and 8/16/2017, it was identified that 3 RNs and 2 LPNs responding to the code on 08/13/2017 did not check Resident #1's MOLST form before initiating or participating in the resident's CPR.</p> <p>During interviews on 8/15/2017 and 8/16/2017, 2 of 12 licensed nursing staff did not know to check the MOLST form to identify the code status of a resident.</p> <p>Resident #1 was observed on 8/16/2017 at 11:07 AM in her wheel chair participating in a computerized activity. She stated she thought she had gone to the hospital recently, however was unable to recall the incident.</p> <p>When interviewed on 8/15/2017 at 11:25 AM LPN #2 stated she received her CPR certification from outside of the facility and she received facility training to identify a residents' code status on the computer. LPN #2 stated on the date of the incident she heard LPN #1 call</p>	F 155		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2017
NAME OF PROVIDER OR SUPPLIER JAMES SQUARE NURSING AND REHAB CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 918 JAMES STREET SYRACUSE, NY 13203	
(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) COMPLETE DATE
F 155	<p>Continued From page 4</p> <p>for help, entered the resident's room, checked for pulse and respirations and the resident did not have any. LPN #2 stated she left to get the crash cart, called a come to code for the supervisor and returned to the resident's room where RN #3 directed RN #5 to call 911. LPN #2 said RN #3 then asked the resident's code status. LPN #2 stated she "thought" the resident was a full code. She stated RN #5 went to the computer while on the phone with 911 and pulled up the resident's information and determined the resident was a DNR. She stated the RN Supervisors took over and she left.</p> <p>When interviewed on 8/15/2017 at 2:55 PM, RN #7 stated she provided CPR training for the facility and some staff obtain their certification from an outside source. She stated all licensed staff were required to have CPR certification and if requested, CNA's were included in the class. She stated staff received education on identifying a resident's code status when trained for CPR. She stated a resident's code status was identified by looking at the MOLST on the unit and by looking in the computer. She stated that, additionally, residents with a white bracelet with black background and white print indicated a full code and a resident with a white bracelet with white background and red print indicated DNR. She stated that, additionally, a red dot located at the head of the bed indicates DNR. When asked for documentation of training provided on this information or an attendance list for this training she was unable to provide this surveyor with any documentation. She stated she provided the education to staff that received CPR training in the facility.</p> <p>When interviewed on 8/15/2017 at 1:37 PM RN #3 stated the facility training identified DNR residents as those that wore white and black</p>	F 155		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2017	
NAME OF PROVIDER OR SUPPLIER JAMES SQUARE NURSING AND REHAB CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 918 JAMES STREET SYRACUSE, NY 13203		
(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) COMPLETE DATE
F 155	<p>Continued From page 5</p> <p>bracelets and CPR residents did not have anything. RN #3 stated if the resident did not have a bracelet she would look at the MOLST form. She stated if she was unable to identify the residents' code status she would initiate CPR. She stated residents also had a little sticker the size of a quarter on the head of the bed to indicate DNR. RN #3 stated she did not know the policy regarding code status as she had not looked at it. She stated on 8/13/2017 she heard a come to code, arrived on the unit, met LPN #2 in the hall and LPN #2 stated Resident #1 was a full code. She stated when she arrived in the room LPN #1 was doing chest compressions without a back board and she did not believe the compressions were effective without the board. RN #3 stated she obtained an airway and RN #5 went to look at the medical record. She stated the resident's pulse returned and the resident had become responsive when RN #5 returned to the room and told them she was a DNR. RN #3 stated she did not look for facility indicators including the MOLST prior to initiating CPR and she took the LPN's word for it.</p> <p>When interviewed on 8/16/2017 at 11:20 AM, RN #5 stated she did not recall if she received facility training on a resident's code status. She stated when the incident occurred and she responded to the code, LPN #1 was doing chest compressions. RN #5 said she followed RN #3 out into the hall way to obtain an airway. RN #5 stated she went to the computer to obtain the resident's medical records for transport and identified the resident's code status was a DNR while calling 911. RN #5 stated she then went to the resident's room and told RN #3 the resident was a DNR and at that time the resident had a pulse and CPR had stopped.</p> <p>When interviewed on 8/23/2017 at 11:05 AM,</p>	F 155		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2017	
NAME OF PROVIDER OR SUPPLIER JAMES SQUARE NURSING AND REHAB CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 918 JAMES STREET SYRACUSE, NY 13203		
(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) COMPLETE DATE
F 155	<p>Continued From page 6</p> <p>the Medical Director stated she identified the resident code status by the computerized medical record, a red dot on the resident headboard, and the resident's bracelet. She stated since the incident occurred she thought some education had occurred. She stated there was a MOLST book on the units however when a resident was unresponsive the staff should check the computer rather than "hunting down the MOLST" and then check the wrist band. She stated all identifiers should be in synch. She stated she reviewed the policies for the facility and was unable to recall if the facility had a policy on identifying a resident code status.</p> <p>When interviewed on 8/23/2017 at 11:55 AM, LPN #1 stated she had not received any training on CPR or on identifying the residents code status prior to the incident. LPN #1 stated she was unable to locate a policy prior to the incident. She stated on 8/13/2017 when Resident #1 became unresponsive, she yelled for help, LPN #2 responded, and they both checked for pulse and respirations. She stated LPN #2 reported to her that Resident #1 was a full code. She stated she began CPR and LPN #2 went to call a code blue. She stated she did not have a back board and when LPN #2 went to retrieve one she heard her tell the RNs the resident was a full code. She stated all 3 RNs entered the room as she provided CPR. She said RN #3 assisted her with obtaining an airway and RN #5 went to call 911. LPN #1 stated, while RN #4 was setting up the AED, she had stopped to cut the residents clothing and reinitiated CPR. She stated RN #5 returned to the room and announced Resident #1 was a DNR at that time, the resident began to arouse, and we continued to monitor her until the ambulance arrived. She stated she received a call from the facility inquiring about the incident</p>	F 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/06/2017
NAME OF PROVIDER OR SUPPLIER JAMES SQUARE NURSING AND REHAB CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 918 JAMES STREET SYRACUSE, NY 13203		
(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) COMPLETE DATE
F 155	<p>Continued From page 7</p> <p>the following day and was asked if she checked the residents' bracelet or the red dot on the bed that indicated the code status and she stated she was not aware of any of the indicators. She stated she was not aware to check the MOLST prior to initiating the CPR.</p> <p>When re-interviewed on 9/6/2017 at 11:34 AM, RN #3 stated she did not check the Resident #1's identification band or MOLST form prior to participating CPR. She stated she took direction from LPN #2 when she stated the resident was a full code. She stated she did not know the policy of the facility when determining the residents code status and "assumed it was her responsibility to check the residents code status before initiating CPR."</p> <p>10NYCRR 415.3(e)(1)(ii)</p>	F 155		

CENTRAL NY HEALTH

Syracuse nursing home faulted for saving woman who did not want to be saved

Updated 7:40 AM;

Posted 7:32 AM



The former James Square nursing home at 918 James St. in Syracuse, now known as Bishop Rehabilitation & Nursing Center(Mike Greenlar)

51

270
shares

By James T. Mulder, jmulder@syracuse.com,
syracuse.com

SYRACUSE, N.Y. - The state has faulted a Syracuse nursing home for saving the life of a resident who did not want to be saved.

Nurses at the former James Square Health and Rehabilitation Centre at 918 James St. performed cardiopulmonary resuscitation on a resident Aug. 13 even though the woman's medical record showed she did not want the life-saving treatment, according to a state Health Department inspection.

The woman's records stated she did not want to be resuscitated or intubated, wanted limited medical interventions and wished to be sent to the hospital only if necessary.

But nurses took all those emergency actions anyway after the woman was found not breathing, unresponsive and without a pulse.

By the time a nurse noticed on the resident's chart she had a do-not-resuscitate order, the woman had already been revived and taken by ambulance to a hospital.

The inspection report does not identify the resident or disclose her age. The report describes her as an amputee with chronic pain, anxiety and cognitive impairment.

Nursing home and hospital patients near the end of life have a right to refuse or discontinue treatments and make their wishes known in a medical orders for life sustaining treatment, or MOLST, form. All health care professionals are supposed to follow these orders.



Stop fraud.



MN Dept. of Commerce

[Learn more](#)

The James Square resident had a MOLST form dated Aug. 18, 2016. A doctor also had documented her status as do-not-resuscitate, DNR for short, and no-not-intubate.

The inspection report says five nurses who responded to the emergency did not check the patient's MOLST form before starting or participating in CPR.

In addition to that form, residents at the nursing home with DNR orders wear white and black bracelets and have red dots on the headboards of their beds.

The nurse who called for help after finding the woman unresponsive said she was never trained how to determine if a resident has a DNR order.

After being evaluated at the hospital, the woman was returned to the nursing home the same day unharmed, according to a plan of correction James Square submitted to the state.

The nursing home said it would educate nurses on how to determine if a resident has a DNR order or other advance directives.

James Square was taken over by a new owner Dec. 15 and has been renamed Bishop Rehabilitation & Nursing Center. Margaret Mary Wagner, the facility's new administrator, was not familiar with the incident.

"This is a human business and people are going to make mistakes," Wagner said. "When something like that happens you have to do a root cause analysis then change the process."
