STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLER POINTE, A PROSPERA COMMUNITY	**3500 21ST ST SE MANDAN, ND 58554**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, information from the complainant, review of the facility reported incident investigation, review of facility policies, review of personnel records, and staff interview, the facility failed to immediately start Cardiopulmonary Resuscitation (CPR) on 1 of 1 closed resident record (Resident #1) who requested CPR in the event of absence of pulse or respirations. Failure to immediately start CPR contributed to Resident #1's death. During the complaint survey on [DATE], the survey team determined a potential Immediate Jeopardy (IJ) situation existed. The IJ potential resulted from review of Resident #1's medical record, the facility reported incident investigation, personnel records, and staff interview which showed residents were placed in an immediate dangerous situation due to the delay of CPR. [DATE] at 5:10 p.m. - The survey team contacted the management staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation. [DATE] at 5:55 p.m. - The survey team notified facility administration of the IJ situation and requested they develop a plan for abatement of the immediate jeopardy. [DATE] at 10:20 a.m. - The SSA notified the regional office of the immediate jeopardy situation. [DATE] at 1:30 p.m. - The survey team determined the IJ situation at a scope/severity of J was abated and reduced to a scope/severity of G. Findings include: Review of the facility policy titled CARDIOPULMONARY RESUSCITATION (CPR) occurred on [DATE]. This policy, revised [DATE], stated, . Cardiopulmonary Resuscitation (CPR) certification is mandatory for all licensed nursing employees. Each location will assign an employee responsible to be sure that all licensed nurses have current CPR certification. This will be reported to the administrator annually. CPR must be initiated unless the resident has a do not resuscitate (DNR) order, the resident has no advance directive on file, the resident does not have a valid DNR on file that includes a medical order issued by a physician or other authorized non-physician practitionerthe (sic) resident has obvious signs of clinical death . Review of the facility policy titled ADVANCE CARE PLANNING AND ADVANCE DIRECTIVES occurred on [DATE]. This policy, revised [DATE], stated, . PURPOSE: To provide each resident the opportunity to make decisions regarding future medical care . Cardiopulmonary Resuscitation (CPR): Any medical intervention used to restore circulatory and/or respiratory function that has ceased. Residents . have the right to make decisions concerning medical care, including the right to accept or to refuse medical or surgical treatment. Review of Resident #1's medical record occurred on [DATE] and identified medical [DIAGNOSES REDACTED]. Resident #1's North Dakota Physician Orders for Life Sustaining Treatment (ND POLST), signed by Resident #1 on admission ([DATE]), identified the following instructions: FIRST follow these orders, THEN call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for [REDACTED]. Resident #1's POLST identified the following: A. CARDIOPULMONARY RESUSCITATION (CPR): CPR/ATTEMPT RESUSCITATION . B. MEDICAL INTERVENTIONS: Patient has a pulse and/or is breathing : FULL TREATMENT - Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.C. ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: . Artificial nutrition and hydration unless it provides no benefit. Review of Resident #1's physician's orders, dated [DATE], stated, ND POLST (A) CPR/Attempt RESUSCITATION. Review of nurses' progress notes identified the following: * [DATE] at 5:38 p.m. - . Met with resident in resident's room to complete admission paperwork. Resident was admitted from (name of hospital) for continues (sic) therapies after being admitted for [MEDICAL CONDITIONS]. * [DATE] at 11:00 p.m. - Resident sitting up on side of bed. He had moderate chunky, food consistency emesis. BP (blood pressure) ,[DATE]; P (pulse) 121; R (respirations) 18; T (temperature) 98.2; O2 (oxygen) 94% RA (room air). Lung sounds clear. Bowel sounds hypoactive. Abdomen distended non-tender. Asked resident if he was feeling like he was going to throw up, resident stated in a clear voice, 'No.' . Resident stated to gag. [MEDICATION NAME] (medication for nausea) applied topically to wrists. Brought [MEDICATION NAME] suppository in and resident turned to his left side. Administered suppository. Resident had moderate soft brown bowel movement. BP ,[DATE]; P 91; R 18; T 98.4; O2 94% RA. * [DATE] at 12:19 a.m. - Approached resident asking if he was alright (sic) still. Resident requested that I take off his wraps on his legs and stated that he was alright (sic). Removed ace wraps from legs. Bowel sounds WNL (within normal limits) all quadrants. Resident safe and secure laying in bed on his back. * [DATE] at 1:24 a.m. - CNA (certified nursing assistant) requested me to come to his room. Apical heart rate not audible. Sternum rub completed without response. (Name of resident's mother) . voice message left at 0126 (1:26 a.m.). CPR initiated immediately. Received follow up report from (nurse) from (hospital) emergency room at 0240 (2:40 a.m.) stated resident deceased . The nurse's documentation of CPR initiated immediately differs from the facility's investigation (timeline and interviews) as listed below. The initial report to the SSA Allegation of Abuse and Neglect, Allegation of Suspected Vulnerable Adult abuse, Neglect, or Exploitation report, dated [DATE], stated, . 8. Briefly Describe the Alleged Incident and/or Injury: Resident ceased breath sounds. CNA (#4) notified nurse (#1). Nurse (#1) checked pulse and did sternal rub. Nurse did not initiate CPR on full code resident immediately. Resident expired. Review of the facility's investigation identified the following timeline of events on [DATE]: 1:04 a.m. (unit camera footage) - CNA (#4) goes to corner of (Unit) where Resident #1's room was located 1:21 a.m. (unit camera footage) - Nurse (#1) goes back to above corner 1:23 a.m. (unit camera footage) - Nurse (#1) goes back to above corner (nurse's progress note stated apical pulse not audible, sternum rub completed and no response) 1:26 a.m. (unit camera footage) - Nurse (#1) returns to nursing station, is on phone/at computer 1:26 a.m. (unit handheld phone) - Call to Resident #1's mother 1:29 a.m. (unit handheld phone) - Call to (another unit) nursing station 1:30 a.m. (unit handheld phone) - Call to Resident #1's son 1:31 a.m. (unit handheld phone) - Call to Resident #1's daughter 1:32 a.m. (unit handheld phone) - Call to (another unit) nursing station 1:39 a.m. (unit desk phone) - Call to on-call provider 1:41 a.m. (unit camera footage) - Nurse (#2) arrives on unit 1:42 a.m. (unit desk phone) - Call to 911 1:43 a.m. (unit camera footage) - Nurse (#1) returns to above corner (per information from interviews - CPR initiated at this time) 1:44 a.m. (unit camera footage) - Nurse (#3) comes with AED, Nurse (#2) comes with crash cart 1:49 a.m. (camera footage) - EMS (emergency medical system) arrived 1:59 a.m. (camera footage) - EMS leaves building with resident 2:40 a.m. (unit desk phone) - Incoming call from ER The facility's investigation report included the following staff interviews: * Nurse #2 interview - [DATE] . Went down to (unit). (Nurse #1) stated she just lost a patient. (Nurse #2) asked the code status. (Nurse #1) said he was a full code. (Nurse #2) stated that she needed to start CPR. (Nurse #1) stated that she has never done CPR and didn't have the crash cart. (Nurse #1) was trying to call the family. (Nurse #2) stated you are going to learn how to do CPR right now. * Medical Provider #6 interview - [DATE] (Medical Provider #6) did not have a call in regards to (Resident #1) until last evening. (Nurse #1) called the switch board to tell (Medical Provider #6) that Resident #1 had passed away. (Nurse #1) tried to do a sternal rub. (Medical Provider #6) told her (Nurse #1) to start CPR and call 911. (Nurse #1) responded by saying 'okay'. * CNA #5 interview - [DATE] Looking for (CNA #4 and Nurse #1). Went into Resident #1's room. (Nurse #1) said he was dead. (Nurse #1) went to call provider. CPR was not issued

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

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 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) right away as (Nurse #1) did not know his code (status). He started CPR 5ish minutes later. (Nurse #2 and Nurse #3) came with crash cart. (Nurse #3) put on AED (Automated External Defibrillator) pads. * CNA #4 interview - [DATE] . She (Nurse #1) checked his pulse. (Nurse #1) called (CNA #5) to room. (Staff #4) cleaned him up. (Nurse #1 and Nurse #2) later started CPR. * Nurse #1 interview - [DATE] at 11:56 AM . Went and checked on him, took wraps off. (Staff #4) in room getting ready to clean him up, fine/still alive, walk out of the room and returned, no heart rate called mom, called (Medical Provider #6), called 911, CPR initiated. EMS arrived quickly and took over, transported to ED (emergency department). Not current on CPR. Says has never dealt with a code before. * Nurse #3 interview - (Nurse #1) called (Nurse #3) to see what to do when you can't get ahold (sic) of a family member when someone passes away. (CNA #4) went into his room and said he was not breathing. (Nurse #1) told (Nurse #3) who it was and he brought him up onto the computer. (Nurse #3) said he's a full code. You need to start CPR, I will be right over. He ran over and pulled the crash cart and grabbed the AED. (Staff (#1)) initiated CPR after being told. AED advised no shock. (Nurse #1) was doing CPR and (Nurse #2) was bagging him. EMS showed up 5 minutes later. (Nurse #3) told (Nurse #1) to document thoroughly. (Nurse #3) expressed that the documentation was not what actually happened. The Final Report Form sent to the SSA on [DATE], stated, . Results of Investigation: Nurse did not initiate CPR until greater than 10 minutes post being alerted of respiratory arrest. Final Action Taken: Termination. During an interview on [DATE] at 2:09 p.m. an administrative nurse (#7) stated all nurses are required to be CPR certified. The nurse (#7) stated they do not have any documentation of CPR certification for the nurse (#1) involved in the incident with Resident #1. When asked about education of staff regarding code status and initiation of CPR, two administrative nurses (#7 and #8) stated the nurses spoke one-to-one with each other regarding the incident. The facility failed to have an educational meeting with nursing staff and confirmed they lacked documentation of nursing staff education. An administrative nurse (#8) stated they are providing education to CNA staff today ([DATE]) regarding location of the crash cart, code book and AED. When asked regarding the discrepancy between the documentation of the nurse's progress note and the investigation timeline and interviews, the administrative nurse (#8) confirmed the nurse's documentation was not accurate. Review of personnel records for all nursing staff on [DATE], identified four (4) nurses lacked evidence of CPR certification. Review of Nurse #1's personnel file lacked evidence of CPR certification. Nurse #1's personnel file identified the following statement from the nurse regarding the incident with Resident #1: When I was visiting with the other staff nurse (he/she) had asked me if I had started CPR. I informed (him/her) I didn't because I didn't think that I needed to due to his heart rate had stopped. (He/she) said Ok then you should contact (name of unit manager), the floor coordinator or physician. I contacted (name of provider) since (he/she) was the on call physician. (He/she) asked if I started CPR. I said no. She told me that I needed to start CPR. So I went and started CPR. Review of the facility's resident code status report identified 22 residents (current census of 116) requested CPR in the event of absence of respirations or heartbeat. The facility nurse (#1) failed to immediately initiate CPR after assessment that Resident #1 did not have an apical heartbeat and no response to a sternal rub. The facility failed to provide documentation of nurses' education regarding location of residents' code status, when to initiate CPR, and to ensure all nurses had current CPR certification. These actions contributed to the death of Resident #1 and the potential for other residents to be affected by the deficient practice.