STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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 interview and document review, the facility failed to continue cardio-pulmonary resuscitation (CPR) after initiating CPR, in accordance with resident wishes and physician orders [REDACTED]. This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found with an absent pulse and respirations, CPR was initiated, discontinued, then initiated again due to confusion over resident code status and R1 died . The IJ began on [DATE], when R1 was found with an absent pulse and respirations, CPR was initiated and discontinued due to an outdated Do Not Resuscitate (DNR) order, when the updated POLST (Provider Orders for Life Sustaining Treatment) to resuscitate was discovered, CPR was reinitiated unsuccessfully, and R1 died . The administrator and director of nursing (DON) were made aware of the incident on [DATE], and immediately initiated corrective actions. The administrator and director of nursing (DON) were notified of the IJ on [DATE], at 11:15 a.m. The facility implemented corrective action on [DATE]. The immediate jeopardy was removed and the deficient practice corrected on [DATE], prior to the start of the survey and was therefore past noncompliance. Findings include: R1's Admission Record printed [DATE], indicated [DIAGNOSES REDACTED]. R1's physician progress notes [REDACTED]. R1's hospital discharge orders to facility dated [DATE], at 11:45 AM indicated R1's resuscitation status as do not resuscitate (DNR). R1's progress note dated [DATE], at 7:50 p.m. included, R1 was admitted to the facility. The progress note indicated R1 was cognitively intact and, able to communicate needs and concerns without any difficulty. R1's progress note from social worker (SW)-B dated [DATE], at 2:14 p.m. indicated SW-B met with R1 to complete intake paperwork and at R1's request, the meeting was discontinued with SW-B to check back with R1 to complete the intake paperwork. No further SW meetings with R1 were recorded in the progress notes. R1's Provider Orders for Life-Sustaining Treatment (POLST), dated [DATE] directed, Attempt resuscitation/CPR. Full treatment: Use intubation, advanced airway interventions and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments. treatment plan: [REDACTED]. R1's Care plan dated [DATE], included, under the heading of focus; current code (resuscitation) status: Resident and family wants a full code (resuscitation). Under the heading of goal; Directive in place and will be honored during review. Under the heading interventions/task; Staff to follow POLST guidelines. R1's progress note dated, [DATE], at 7:10 a.m. included, CNA (certified nursing assistant) was doing 0620 (6:20 a.m.) round and resident was found gasping for air with a faint pulse. Nurse initiated oxygen and called a code. Staff immediately came up and started CPR until the paramedics arrived. Staff updated the family (FM-A) at 0640 (6:40 a.m.) regarding paramedics doing CPR and informed her that staff will keep them updated. Resident expired at 0700 (7:00 a.m.) according to Paramedics. R1's facility internal investigation interview dated [DATE] included, (Licensed practical nurse (LPN)-A) was on 2nd floor when she heard code Blue called around 6:25 a.m. (registered nurse (RN)-D) and (LPN-A) immediately went to 4th floor. RN-C reported that (R1) was gasping for breath and had a faint pulse. The nursing team immediately started CPR. When we started CPR (R1) did not have a pulse for signs of life. We continued CPR for about 15 minutes. RN-C came back to the scene after checking his POLST and said he is a DNR/DNI. When we figured this out, we stopped everything we were doing. We stopped for about 5 minutes. RN-C couldn't find the paper POLST in the chart so she looked in PCC (facility electronic medical record (EMR)) PCC stated DNR/DNI. The paramedics arrived around 6:40 a.m. and were asking the nurse details about the resident. The nurse had the chart to get information about the resident and came across the POLST that read Full Code. Upon this new information the paramedics and nursing team resumed CPR. There was a 5 minute lapse between stopping CPR and resuming CPR. They did this for 15 minutes with no sign of life. The resident expired around 7:00 a.m. R1's facility internal investigation dated [DATE], indicated that R1 was admitted to the facility on [DATE] and on [DATE] SW-B met with R-1 and confirmed that R-1 wished to be full code. SW-B completed the new POLST with R1 and faxed it to nurse practitioner (NP)-J. NP-J returned the signed POLST and SW-B uploaded the POLST into the EMR. NP signed the form and sent it back to writer (SW-B), and writer uploaded the form into PCC (EMR), and it was unknown to writer that resident had a DRN/DNI order in PCC, which he came with to the hospital, that is why writer did not call for a change of POLST from DNR/DNI to full code in PCC. The form was uploaded, however, the physician orders [REDACTED]. When interviewed on [DATE], at 1:25 p.m. RN-H stated that when a POLST (advanced directive with a provider's order) is completed the practice is to place the POLST in the front of the resident's chart and to verify that it matches the resuscitation status order in electronic medical record (EMR) and if it does not, to clarify with the provider. RN-H indicated that when helping a resident with a new POLST a provider's signature is immediately obtained. RN-H stated that when a resident is found pulseless and not breathing, code status is immediately checked by looking for the POLST in the front of the chart and if indicated, then CPR is initiated. When interviewed on [DATE], at 3:05 p.m. RN-E stated that when a POLST is completed with a resident, the POLST is immediately sent to the provider for signature and when that is obtained, the POLST is placed in the front of the resident's chart. RN-E stated on completion of the POLST it is verified that the POLST matches the resuscitation status listed in the EMR. RN-E stated that when a resident is found pulseless and not breathing, code status is immediately confirmed by looking for the POLST in the front of the resident's chart and starting CPR if indicated. The facility policy Cardiopulmonary Resuscitation revised, ,[DATE], directed, A POLST form will be completed on admission by the nurse manager or designee and (reviewed) upon readmission, quarterly, and as needed (such as when a resident is transferred from one care setting or level of care to another; when there is a substantial change in the resident's health status; when the resident's treatment preferences change; for when a primary medical care provider changes). When an emergency occurs, the nurse and/or clinical team will guide care provided, according to the resident and/or resident's representative identified preferences indicated on the physician's orders [REDACTED]. CPR is not discontinued until qualified help arrives, resident pulse and respirations return, or resident is pronounced dead by a qualified personnel such as Paramedic and gives orders to stop CPR. The facility policy POLST Documentation, updated, [DATE], included, under Purpose, The Resident and/or Resident Representative's decision will be entered into the the individualized plan of care/electronic medical record, and will be communicated throughout the facility, so that staff know immediately what action to take or not take when an emergency arises. The facility Addendum to POLST Documentation Policy, dated [DATE], directed, Admitting nurse to review code status with resident immediately upon readmission. The nurse will complete code status order in PCC-and will be reflected automatically in E-MAR. The paper copy of the POLST form shall be placed in the resident's physical chart at the back of the front cover of the chart. POLST form will be reviewed and completed by a licensed professional nurse. Social workers may only facilitate and coordinate meetings with residents, responsible parties and the nurse completing the POLST. The past noncompliance immediate jeopardy began on [DATE]. The immediate jeopardy was removed and the deficient practice corrected by [DATE], after the facility implemented a systemic plan that included the following actions. The facility had conducted a full house audit on [DATE], to ensure POLST and EMR

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

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) matched resident current wishes. The facility ensured every nurse had a current CPR certification on [DATE]. The facility updated their POLST policy and addendum on [DATE], to include a nurse would be responsible to initiate a POLST and have the POLST signed by the provider and then the nurse would update the POLST in the EMR. All nurses were educated prior to working their next shift which was initiated on [DATE]. Audits were to continue and the facility incorporated their action plan into the facility wide quality assurance program. Verification of corrective action was confirmed on [DATE], by interviews of licensed staff, unlicensed staff, and administration, as well as document review including training provided and an audit of medical records.