STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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 initiate timely cardio-pulmonary resuscitation (CPR) in accordance with resident wishes and physician orders [REDACTED]. This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found with absent pulse and respirations, timely CPR was not initiated, and R1 died . The IJ began on [DATE], when R1 was found with an absent pulse and respirations, timely CPR was not initiated, 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 1:00 p.m. The facility implemented corrective action on [DATE], prior to the onsite investigation, and the deficiency is being issued at past non-compliance. Findings include: R1's Admission Record printed [DATE], indicated R1's [DIAGNOSES REDACTED]. R1's admission Care Area Assessment (CAA) dated [DATE], indicated R1 had moderately impaired cognition. R1's Advance Directive Consent Form dated [DATE], directed staff to perform CPR if R1 went into [MEDICAL CONDITION] or respiratory arrest. The document was signed by R1. The Facility Investigation of alleged neglect dated [DATE], indicated registered nurse (RN)-B found R1 with no pulse, no breathing, and eyes open with no response. RN-B notified licensed practical nurse (LPN)-A and RN-A of R1's passing. RN-A asked if RN-B had checked R1's code status. RN-B revealed she had not checked R1's code status. R1's code status was confirmed as full code. CPR was then initiated. The medical director was notified and an order to discontinue efforts and call the time of death was received. Although CPR was initiated, there was a delay of approximately eight minutes. The facility interviewed staff regarding the incident. RN-B was interviewed and placed on suspension for the investigation. The facility initiated education for all staff regarding the Code Blue Response. During interview on [DATE], at 1:38 p.m RN-A was interviewed regarding R1's passing and stated at approximately 9:30 a.m. on [DATE], RN-B came to RN-A and stated R1 had passed away. RN-A asked what R1's code status was and RN-B did not know what R1's code status was. RN-A and RN-B went to the area where the paper charts were and found R1 was a full code (will allow all interventions needed to get their heart started). The physician was on speaker phone with LPN-A doing a telehealth rounding session and the physician directed to do ten compressions for R1 and check for a pulse, and if no response do not continue. RN-A stated about 9:45 a.m. they went to R1's room and performed ten compressions, R1 had no pulse, and efforts were halted. RN-A stated there was no code blue (an emergency situation announced in an institution in which a patient is in cardiopulmonary arrest, requiring a team of providers to rush to the specific location and begin immediate resuscitative efforts) called for R1. RN-A stated RN-B was taken off the floor, talked to by the director of nursing (DON), and has not been back to the unit. RN-A stated the facility started asking staff what they would do if they found an unresponsive person on [DATE]. RN-A stated staff from the day shift received education and as the evening shift came in to work they received education on what to do when you would find an unresponsive person in the facility. RN-A stated you check the resident's code status in the paper chart or have someone look for you. RN-A stated staff had to sign a sheet that indicated they had read the policy and what the expectation of the facility was for an unresponsive person. During interview on [DATE], at 3:20 p.m. nursing assistant (NA)-A was interviewed regarding the passing of R1. NA-A stated that morning R1 was up for breakfast at 8:00 a.m. in the dining room. R1 ate breakfast and did not mention any discomfort. NA-A stated R1 was assisted to bed after breakfast, about 9:00 a.m. NA-A further stated later in the morning, unsure of the time, RN-B called over the walkie talkie that help was needed in R1's room. NA-A stated R1 was laying on right side with a pillow behind the back. NA-A stated RN-B thought R1 had passed away. RN-B went to get the vital machine and there was no blood pressure, no oximetry (measure the oxygen level of the blood). NA-A stated R1 was grayish in color. NA-A stated NA-A went to get RN-A and RN-A was on a telephone conference. RN-B went to get someone else. NA-A never went back into R1's room until R1 was prepared for viewing by the family. On [DATE], at 3:59 p.m. the DON was interviewed and stated RN-A had come to see her after she had a missed call from RN-A. The DON went on to state that RN-A told her there was a problem, that R1 had coded, was a full code and CPR was not immediately initiated. The DON stated the administrator was also informed of the incident at this time. The DON stated they started the investigation immediately, obtained written statements from those involved, and that following interview and obtaining a written statement, RN-B was suspended. The DON stated they had initiated whole house education on how to response to an unresponsive resident, what they would do when a resident is found unresponsive, and what the expectation is. The DON stated staff working during the day shift on [DATE], were asked to read and sign they understood the facility process for a resident that is found unresponsive that included the following, to call for assistance and have someone check the code status for the resident and if a full code, staff would call a code blue and proceed with CPR. If the resident was DNR (do not resuscitate) then staff were to follow the process of expiration. The DON stated a code blue is called to get more staff to the location quickly and for assistance. The DON stated the evening shift on [DATE], was educated on this same process as they came in to work and the rest of the staff continued to be educated when they came for their shift. The DON stated this education was completed by the nurse managers on the unit when the staff entered the facility. The DON stated, on the day of the incident, a code blue was not called for R1 and CPR should have been initiated. On [DATE], at 4:10 p.m. LPN-A was interviewed and stated on the day of the incident of [DATE], she was talking with the physician when RN-B came into the area and stated R1 was cool to the touch and had passed away. RN-B left the area to find RN-A. Then RN-A and RN-B came to the area and checked on R1's code status. R1's code status was listed as full code. LPN-A stated the physician told them to try CPR. LPN-A was not sure of the exact time. When asked about what she would do if a resident was found unresponsive, LPN-A stated it does not matter if the resident is cold you do CPR until called (time of death) by the physician. LPN-A stated our policy indicates if unresponsive, check the paper chart for code status, if full code, call code blue and start CPR. LPN-A stated others could call 911 while CPR compressions are started until emergency management system (EMS) would come and take over the compressions. During a telephone interview on [DATE], at 10:18 a.m. RN-B stated on [DATE], the day of the incident, RN-B entered R1's room at 9:35 a.m. to administer medication. R1 was in bed. RN-B stated R1 did not respond to the greeting from RN-B, that R1's eyes were open, no blinking, and R1's color was gray. RN-B stated the covers were lowered and RN-B placed a hand on R1's chest to see if R1 was breathing and checked R1's right wrist for a pulse. R1's finger tips were a blue, purple color, and that R1's hands and arms were cool to the touch. RN-B stated she called over the walkie talkie for a NA to assist. RN-B went to get the vital machine and did a blood pressure (BP) on the right upper arm and there was no reading obtained. RN-B stated at 9:38 a.m. she went to RN-A's office and they were in a meeting and then talked to LPN-A about what the process was for residents that passed away. At 9:40 a.m. RN-A came out of the office and RN-B stated R1 had passed away. RN-A had asked what R1's code status was. RN-B stated that R1's code status was not checked and they both proceeded to the paper chart where R1 was determined to be a full code. The physician was on the phone and could hear the conversation and told them to do ten chest compressions and check for a pulse

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) and if there was no pulse, to call it. RN-B stated this direction was followed and the time RN-B was 9:42 a.m. RN-B stated following R1's death, she had not done any charting of the incident. RN-B had not called a code blue for R1. RN-B stated, I did not check (R1's) code status and I do not know why I did not check code status. RN-B stated RN-B had CPR certification and was current. RN-B stated she assumed R1 was a DNR/DNI (do not resuscitate/intubate). RN-B stated she was sent home while the investigation was pending. On [DATE], at 11:33 a.m. family member (FM)-A was interviewed and stated R1 was treated well and had no concerns that were shared about the facility. FM-A stated the facility called and stated R1 was found by the nurse and had passed away. FM-A stated the facility did not help R1 and that is why he passed away. The facility implemented corrective action to prevent recurrence by [DATE]. On [DATE], the facility started to educate all licensed nursing staff and unlicensed staff on the Code Blue Response for finding a resident unresponsive. Staff are to immediately check the resident's code status in the paper chart. If DNR, (do not resuscitate) no further action is required. If full code, immediately initiate CPR. 95% of staff were trained prior to survey on [DATE], with a plan in place to retrain the remaining staff prior to working. In addition, staff were interviewed and were able to correctly verbalize understanding of the established CPR policy and procedure. The facility policy Code Blue Response, undated, indicated if a resident is witnessed to become unresponsive or is found unresponsive and is without a pulse or respiration, you must immediately call for assistance and check the paper chart to confirm the resident's code status preference. If the resident code status is indicated Do Not Resuscitate (DNR) no further intervention is required. If the resident has indicated a wish for Resuscitate/full code immediately initiate CPR.