STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moorhead Restorative Care Center	2810 Second Avenue North Moorhead, MN 56560

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 to resident health or safety Residents Affected - Some	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** 43367 Based on interview and document review, the facility failed to provide basic life support, including cardiopulmonary resuscitation (CPR) in accordance with resident wishes and physician orders for full code status of CPR to 1 of 3 residents (R1) reviewed for CPR. This deficient practice resulted in an immediate jeopardy (IJ) situation when R1 was found not breathing and had no pulse. CPR had not been initiated, and R1 died . In addition, the facility policies and practices did not reflect current standards of practice for CPR and lack of timely access to resident's code status placed 18 of 28 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18) whose code status were identified as full code CPR in immediate risk in the event their heart stopped and breathing ceased. The immediate jeopardy began on [DATE], at 4:45 a.m. when R1 was noted to have no respirations or a pulse and CPR was not initiated. On [DATE], at 7:30 p.m. the administrator, assistant administrator, and corporate director of nursing (DON) were notified of the IJ situation. The facility implemented corrective action during the onsite investigation, therefore the IJ was removed on [DATE], when the majority of the staff had been re-educated and plans had been implemented for education for the remaining staff and the CPR policy had been revised. The noncompliance remained at the lower pattern scope and severity level of E, pattern and no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition. The MDS indicated R1's diagnoses included cancer, coronary artery disease (CAD), seizure disorder, and asthma. The MDS identified R1 required extensive assistance of one to two staff for dressing, personal hygiene, mobility in bed, and transfers. R1's care plan last updated on [DATE], identified R1 required physical assistance with toileting, transfers, bed mobility, and personal cares. R1's care plan further identified she was a full code and CPR would be performed as ordered. R1 had advanced directives indicating she had decided to remain a full code. Review of R1's Provider Orders for Life-Sustaining Treatment (POLST) form signed on [DATE], identified R1 was a full code in which CPR would be started and the ambulance would be called for transport to the hospital. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R1's physician orders unsigned dated [DATE], revealed R1 was a full code. Review of R1's current Kardex identified R1 as CPR (Full Code). Review of R1's progress notes dated [DATE], identified the following: -at 5:26 a.m. licensed practical nurse (LPN)-A had been notified by the nurse aide (NA) at 4:45 a.m. R1 appeared to be falling out of bed. LPN-A rushed to assist and R1 appeared to not be breathing. LPN-A checked R1's pulse /heart rate, and oxygen level but neither were present. DON was notified immediately at 5:05 a.m. and certified nursing assistants (NA) were instructed to do post mortem cares. R1's progress note lacked documentation CPR had been initiated on [DATE], following the AHA recommendations when R1's wishes were identified as full code status. Review of the facility resident list provided on [DATE], at 1:30 p.m. verified 18 out of 28 residents current code status were full code. The list identified the following residents had full code orders: (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18). During a telephone interview on [DATE], at 1:30 a.m. nursing assistant (NA)-B stated she had seen R1 on [DATE], at 4:15 a.m. in her room lying in bed and breathing. NA-B verified at 4:30 a.m. NA-A approached her, and informed her something had happened to R1. NA-B entered R1's room right away and saw her as she laid in a low bed; her legs crossed and touched the floor, and her head was on the pillow. NA-B stated she called out R1's name twice and did not receive a response from her. NA-B verified R1 was not breathing however had felt warm to the touch. NA-B stated she called for help as soon as possible over the intercom with her walkie. NA-A verified LPN-A arrived to R1's room approximately five minutes later. NA-B indicated LPN-A checked R1 for a pulse, found nothing, and left R1's room to grab her stethoscope. NA-B stated LPN-A returned to R1's room within a minute, checked for a heartbeat and breathing with her stethoscope and heard nothing. NA-B identified she informed LPN-A R1 was still warm to the touch and a full code, however no CPR was started by any staff present. NA-A left R1's room and headed down the hallway to the computer to verify R1's code status however was unable to locate it. NA-A stated approximately four or five minutes later LPN-A left R1's room and came to the computer down the hallway to locate R1's code status and noted R1 was a full code. NA-B indicated LPN-A called the interim director of nursing (IDON), corporate director of nursing (DON), and the family and informed them of R1's passing indicating the facility had not started CPR on R1 because she was already dead. NA-B verified both her and NA-A were not CPR certified and had not initiated CPR on R1. Additionally, NA-B stated LPN-A had not started CPR on R1. NA-B indicated CPR should have been started on R1 until the code status had been verified. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE], at 2:30 a.m. NA-A stated at approximately 4:30 a.m. on [DATE], NA-A opened R1's door and noted R1 laid across the bed, motionless and not breathing. NA-A felt R1's skin and noted it was warm to touch. NA-A indicated something did not feel right and NA-A called on the walkie for assistance. NA-A confirmed she had not started CPR, left R1's room, and returned a few minutes later with NA-B, LPN-A and LPN-B. NA-A identified LPN-A checked R1's heartbeat with a stethoscope and verified R1 had no pulse. NA-A stated LPN-A stated out loud R1 was still warm and not breathing. NA-A indicated LPN-A instructed NA-B to leave the room to check R1's code status at the nurse's station on the computer. NA-A verified NA-B had been gone for approximately two minutes and did not return to the room. NA-A stated LPN-A then left the room to check R1's code status. NA-A indicated LPN-A returned to R1's room approximately 5 minutes later, stated R1 was a full code however CPR had never been initiated on R1. NA-A verified CPR should have been started right away when R1 was noted to have no pulse or respirations if the code status was not known. NA-A stated she had been unable to see the code status of each resident on the computer and therefore relied on the staff nurse to inform her what the code status was for each resident. During a telephone interview on [DATE], at 10:20 a.m. LPN-A indicated she had checked on R1 at approximately 4:00 a.m. on [DATE]. LPN-A stated she entered R1's room and noted she was breathing fine, had her oxygen on per nasal cannula and was asleep. LPN-A indicated she left R1's room and walked to the front of the building to the nurse's station to chart. LPN-A verified at 4:15 a.m. NA-A informed her and NA-B R1 laid partially out of bed and if staff did not arrive there soon R1 may fall. LPN-A stated NA-A and NA-B headed down to R1's room and LPN-A finished her charting. LPN-A indicated approximately five minutes later she walked down the hallway with LPN-B and heard a nursing assistant yell out from R1's room, I can not wake her up, wake up wake up. LPN-A stated she entered R1's room along with LPN-B and R1 looked pale and was not breathing. LPN-A indicated she touched R1 on the arm and the neck and noted she was cold and attempted to find a pulse. LPN-A verified she knew R1 had no signs of life. LPN-A stated she ran down the hallway, grabbed her stethoscope and returned to R1's room a minute later. LPN-A stated she and LPN-B listened for a heartbeat and noted R1 had no pulse. LPN-A indicated she had asked NA-B to go check the code status of R1. LPN-A indicated NA-B had been gone approximately two minutes and returned to R1's room stating she could not find R1's code status. LPN-A stated she left R1's room and arrived at the nurse's station to check R1's code status on the computer. LPN-A indicated the internet was slow and approximately six minutes had passed before she verified R1 to be a full code. LPN-A stated she returned to R1's room and LPN-B informed her R1 was gone and there were no signs of life. LPN-A confirmed no staff initiated CPR on R1. LPN-A identified she called the IDON and informed her what had happened and then contacted R1's family. LPN-A expressed concerns about how difficult it had been to get into the computer to find R1's code status that morning and she stated she needed quicker access so necessary action could have been taken. During an interview on [DATE], at 1:18 p.m. registered nurse (RN)-A stated the resident code status could be found quickly in the electronic health record (EHR) on the face sheet underneath their picture and on the facility report sheet. RN-A stated when a resident was found unresponsive with no pulse or respirations, staff were expected to initiate CPR until the code status was identified, call 911, and then the doctor. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE], at 3:10 p.m. LPN-C stated part of her role in the facility consisted of staff education. LPN-C indicated when staff came upon an unresponsive resident without a pulse, not breathing, and not sure about the code status it would be expected CPR be started until the code status could be verified. LPN-C indicated the facility policy was written according to the American Heart Association guidelines. LPN-C verified the facility policy identified if the resident was cool to touch, CPR should not be started however LPN-C indicated cool to touch did not mean a resident had passed away. LPN-C stated the facility policy was therefore not clear and should probably be revised. LPN-C verified the staff would be expected to complete the assessment even if a body was cold as to whether CPR should be started, call 911 while they waited for a licensed staff to arrive at the scene. LPN-C stated she informed staff to look at the care plan and the Kardex under safety to locate the resident's code status. During an interview on [DATE], at 3:45 p.m. DON stated the resident's code status could be located in the EHR front screen, the Kardex, or the care plan. DON stated on [DATE], NA-A found R1 unresponsive and notified LPN-A. DON indicated LPN-A and LPN-B both evaluated R1's status and agreed it was too late to initiate CPR, and confirmed therefore CPR had not been performed on R1. DON confirmed when a resident was found unresponsive, with no pulse or respirations, and cold to the touch, staff were expected to initiate CPR if they were a full code. During a follow up interview on [DATE], at 11:30 a.m. DON verified the extra wording on the facility policy Emergency Procedure- Cardiopulmonary Resuscitation (e.g. pallor, cool to the touch, rigor mortis) was added by herself and the administrator after R1 passed away on [DATE]th, 2022. DON stated the policy had misleading information. DON stated CPR should have been started on R1 when she became unresponsive and was noted to be without a heart beat and respirations. During an interview on [DATE], at 4:40 p.m. IDON stated the examples of when not to complete CPR in parenthesis: pallor, cool to the touch, rigor mortis were provided on the facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation were to be used by the staff nurses as a guide and the staff nurses were expected to use their judgment to determine if CPR should be initiated or not when the CPR status was unclear. The American Heart Association current guidelines dated 2010, identified: The healthcare provider should take no more than 10 seconds to check for a pulse and if the rescuer does not definitely feel a pulse within that time period, the rescuer should start CPR beginning with chest compressions. Ideally, the healthcare provider performs a pulse check at the same time as the check for no breathing or only gasping to minimize delay in detection of cardiac arrest and initiation of CPR. Begin chest compression as quickly as possible after recognition of cardiac arrest. All patients in cardiac arrest should receive resuscitation unless the patient has signs of irreversible death (eg, rigor mortis, decapitation, decomposition, or dependent lividity.) Review of a facility policy titled Emergency Procedure-Cardiopulmonary resuscitation undated, received on [DATE], identified if a resident was found unresponsive and not breathing a licensed staff member who was certified in CPR should initiate CPR unless: it was known a DNR order existed for that resident and prohibited CPR or there were obvious signs of irreversible death (e.g. pallor, cool to touch, rigor mortis). Furthermore, when a resident's DNR status was unclear, CPR would be initiated until it was determined there was a DNR or physician's order not to administer CPR. (continued on next page)

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